The Relapse Story:
its rituals and meanings

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ABSTRACT

Alcohol relapse is a major problem and challenge for health care professionals working in the field of addictive disorders. Despite the array of relapse prevention methods available, alcohol misusers become caught up in a cycle of relapse which is difficult to break. What does the relapse experience mean for the client? The purpose of this study is to combine understanding of the relapse story and its sequences with the intention of improving therapy and assisting patients and their families. In this qualitative study, the chains of events in five case studies or stories were investigated and analyzed in order to uncover deeper meanings behind alcohol relapse. Internal and external validity, in this case study, were strengthened by the use of control questions and pattern-matching. Multiple-case interviews revealed important themes including control, ritual behavior, childhood trauma, and guilt. Using the relapse interview as a guide, a new conversational model or therapeutic approach is proposed where the therapist and the client together, examine, reflect over, and learn from the alcohol relapse story. Moreover, the methodology in this approach, allows the therapist to combine research with clinical treatment of the client.
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Chapter I

Introduction

1.1 The Alcohol Relapse Phenomenon

Alcohol use disorders affect approximately 12 percent of the population and cause immense suffering to patients, their families and to those around them (Department of Health and Human Services, 2011). Every alcoholic directly affects the lives of at least four to five other people. But alcoholism is difficult to define and there is no universally agreed-upon definition which can complicate clinical assessment and frequently results in a failure to identify addiction in families (McGoldrick, 2005). The National Council on Alcoholism (1992) defines alcoholism as:

A primary, chronic disease of genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation of the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

Over time, alcoholism distorts patterns of behavior, communication and emotional patterns evolving within the family system. Historically, these families have been referred to as “alcoholic systems” where all family members are affected. Family roles can become reversed or inappropriate, boundaries between family members become rigid or diffuse, and family triangles become activated depending on whether the alcoholic is active (McGoldrick, 2005). An alcoholic’s behavior and mental impairment, while drunk, profoundly impacts those surrounding him and can lead to isolation from family and friends, marital conflict and divorce, or contribute to domestic violence. Alcohol use disorders can also lead to child neglect with subsequent lasting damage to the emotional development of the children (Tucker, 2011).

Fewer than 25 percent of those with drinking problems seek help from alcohol treatment programs or professionals or from mutual-help groups such as Alcoholics Anonymous (AA). For those patients who do seek help, the alcohol problem is generally more severe and abstinence often is an appropriate drinking goal in individual treatment programs (Tucker, 2011).

Alcohol use disorders are often chronic, recurring conditions involving multiple cycles of treatment or intervention, periods of abstinence and relapse. To disrupt this cycle, researchers and clinicians are increasingly developing, implementing, and evaluating “continuing care” interventions. These interventions, which may consist of group counseling, cognitive behavioral therapy, or other approaches, are provided for some period
of time following the initial acute care episode and their goal is to stabilize the patients’ situation, lower relapse rates, and thereby also reduce the need for additional treatment episodes (McKay, 2011).

No consensus has emerged on a definition of relapse but in practice, the term most often has meant a return to alcohol after a period of voluntary, committed abstinence (Leonard & Blane, 1999). Abstinence represents the most stable form of remission for most recovering alcoholics. Relapse following alcohol treatment is a major problem for individuals who are alcohol dependent (National Institute on Alcohol Abuse and Alcoholism, 2007). It is estimated that 50 to 90 percent of those who receive treatment for their alcoholism will relapse within two to four years (McGoldrick, 2005). Research concerning maintenance of behavior change and/or relapse is considered to be among the most important clinical research areas in the study of addictions (Leonard & Blane, 1999).

I intend to explore the phenomenon of relapse among those who have an alcohol use disorder.

1.2 Research in Addiction and Alcohol Relapse

Different positions and approaches in research studies on alcohol relapse abound yet it was difficult to find articles specifically aimed at my topic of research. One can then deduce that my research theme is quite unique. The following studies take cognitive-behavioral and psychoanalytic views, and a “narrative” approach to psychotherapy.

One article by Witkiewitz and Marlatt (2004), deals with a reconceptualized cognitive-behavioral model of the relapse process. Emphasis here is on dynamic interactions between intrapersonal determinants and situational determinants. It has been found that there is a strong link between negative affect and relapse to substance use. In addition, interpersonal determinants, or levels of emotional support, are highly predictive of long-term abstinence rates. Marlatt’s earlier model has been criticized for the hierarchical classification of relapse factors but here, he proposes that multiple influences trigger and operate within high-risk situations and influence the system. He no longer presumes that certain factors are more influential than others. He emphasises a reciprocal causation between factors with feedback loops that allow for the interaction between coping skills, cognitions, craving, interpersonal factors (e.g. negative affect), intrapersonal factors (e.g. marital happiness), and substance use behavior. He acknowledges the complexity and unpredictable nature of substance use.

McKay (2006) takes up this reformulation of the Marlatt and Gordon model and points out that research methodology makes it impossible to adequately test many of the components in these dynamic models. He points out that the real key to understanding why a particular relapse episode occurs, likely lies in experiences and events in the hours and minutes leading up to the onset of that episode. He goes on to explain that in many relapses there is a
moment of truth, so to speak, in which the substance abuser makes a final decision, whether consciously or not, to go ahead and have that drink. Unfortunately, none of the cutting edge methods are really able to capture what is going on in the substance abuser’s mind at that moment. The only way to obtain fairly detailed information on the thought processes, moods and experiences of the relapser in the moments before the relapse commences is through interviews conducted after the fact. Such data, he points out, are likely to be biased and are only the relapser’s subjective perceptions. He concludes though that despite all the advances in assessment technologies available to study relapse, there is still convincing rationale for not abandoning the practice of asking the substance abuser how a relapse episode came about.

Khantzian’s (2011) article, from a psychoanalytic view, emphasizes the painful feeling states, sense of alienation, and disconnection, from self and others, that produce enormous distress and suffering which lead to addictive behavior. Misuse provides “magical” relief and restores a sense of control that counters feelings of helplessness. He also takes up the powerful and bewildering experience of addiction experience. He also notes Marlatt and Gordan’s model and the general tendency in the era of “biological psychiatry” to view relapse as being precipitated by external “triggers”. In another article, Khantzian (1986) emphasizes the misuser’s difficulties in managing their feelings. He explains, “...they are poorly regulated, hardly tolerated, and more frequently, expressed through action.”

P. Gardner and J. Poole (2009) in their article, “One Story at a Time: Narrative Therapy, Older Adults and Addictions”, point out that significant gaps have been identified in both the research and practice of narrative therapy. The narrative approach is a form of therapy using narrative which centers clients as the experts in their own lives. Initially developed during the 70s and 80s, it draws on some of the ideas of philosopher Michel Foucault as a way of theorizing power and knowledge and the relationship of social context to individual experience. It is the individual’s beliefs, skills, principles, and knowledge that, in the end, help him regain his life from a problem. In practice a narrative therapist helps clients examine, evaluate, and change their relationship to a problem by collaborating with the client; that is, the therapist poses questions that help people externalize a problem and then thoroughly investigates it (Flaskas, 2002).

One of these gaps discussed in this article, relates to addictions and in particular, understanding of narrative therapy with addiction in older adults. With a philosophy of modified harm reduction and a critique of abstinence-based models, their study team used terms such as “substance misuse” instead of addictions. Participants in the study, were not subjected to intake assessments, nor were they asked to detail the “stage” of their addiction. This is a very thought-provoking study where care is taken to show respect in many ways and to avoid concentrating on alcohol as the problem. All participants had experienced a range of therapies and supports prior to the study. Overall, findings
suggested that narrative therapy is a helpful therapeutic approach for older people with addictions.

1.3 Background

My interest in the relapse story actually began with a long fascination for the concept of ritual—both in religious and everyday life. As a reminder as to just how far back in time this interest reaches, I recently came across two term papers from my undergraduate and graduate studies—one was on Freud’s *Moses and Monotheism* and the other, *Totem and Taboo*. This must indeed serve as ample evidence of my enduring enthusiasm for the psychology of religion and ritual. I find the phenomenon of ritual captivating. It has a sense of being both dynamic and mysterious yet at the same time, soothing and safe. It has an elusive quality that makes it difficult to define and as of yet, no one is in agreement over the definition.

During my years of clinical experience at an out-patient alcohol clinic, patients often told of a childhood devoid of the usual “positive” family rituals one often associates with a happy childhood and secure upbringing. But they did tell of rituals nonetheless—albeit more unhappy and frightening ones. They told of a childhood growing up in a home plagued by alcohol abuse and/or psychiatric illness. They told of Christmastime rituals fraught with tension, alcohol and physical and verbal abuse. They told of dinnertime rituals burdened by silence and bedtime rituals charged with anxiety. They also told of their own alcohol misuse as adults.

I have listened to many stories of alcohol relapse. None of the patients take their drinking episodes lightly. Most of them had been committed to a life of sobriety and the relapse comes unexpectedly. It almost sweeps them off their feet. It takes a while for them to regain their equilibrium. With others, drinking periods come more frequently but they are always powerful. It is a phenomenon that takes over while the patient is convinced that he has lost control. The relapse story almost always begins long before alcohol makes its appearance and it ends long after the drinking ends. It must take its time. I grew to realize that their relapse stories had striking similarities and differences about them. The same performance, more or less, was being acted out over and over again. Each subsequent relapse included the same cast of characters, the same setting, the same script and the same props.

I will employ the use of the theatrical or performance metaphor for these stories and the concept of ritual will serve as a backdrop. This paper will focus on the relapse story and on how the patient relates it. I believe that there is much valuable information to be uncovered by closely examining the relapse sequence. I also believe that the relapse story is less about the drinking and more about the patient communicating a message.
1.4 Purpose

The purpose of this paper is to understand the relapse story and its sequences with the intention of improving therapy and assisting patients and their families.

I will investigate and address the following research questions:

How do patients tell their relapse story?

How is the chain of events connected with meaning and control?

What is the dramaturgy of the relapse story?

How can professional helpers form a deeper understanding of the relapse story to improve therapy and assistance?

1.5 Communication Model and Relapse Process

In this study, I will utilize a classic communication model. It is a still picture of a moving process and will be useful in identifying the basic components of the communication process and how they are related. A model aids in conceptualizing processes and in generating questions for richer forms of theory. Models are also helpful as metaphors that guide one’s ability to visualize concepts of interest and help to clarify complex processes.

In 1948, Shannon and Weaver were first to develop a linear model of communication and proposed six elements of communication: source, encoder (person sending the message), message, channel and decoder (person receiving the message), and receiver. Wilbur Schramm, in 1954, expanded on this model by incorporating the study of human behavior in the communication process. He emphasized the process of encoding and decoding the message and included the concepts of “feedback loop” (information that comes back from the receiver to the sender) and “field of experience” (an individual’s beliefs, values, experiences and learned meanings both as an individual and part of a group). Feedback refers to a response which can be positive (when the required result is achieved) or negative; instantaneous (when the result is immediate) or delayed. Feedback is used to gauge the effectiveness of a particular message put forth or situation that has taken place (Kulvete, 2005).

Schramm suggests that the message can be complicated by different meanings learned by different people. “Noise” indicates those factors that disturb or otherwise influence messages as they are being sent. A message can have both surface and latent meanings. Other characteristics of messages that impact communication between two individuals are: intonations and pitch patterns, accents, facial expressions, quality of voice, and gestures.
The successful transmission of a message depends on whether this message will be accepted over all the competing messages (Chandler, 1994).

The communication model also shows us that all communication takes place in a certain context which can be physical (place, temperature etc.), social (status, rolls, norms), psychological (serious, friendly, nervous etc.), and during a certain period in time (in relation to another happening, time of day etc.) Context plays a major role in how we interpret meaning and intention through communication (Lundsbye et al., 2007).

In this study, I intend to gather information for my research through “focused interviews” with out-patients at the clinic. I will utilize the communication model developed by Shannon and Weaver as this model will provide a structure and rationale for my research. It will help in describing, explaining and interpreting what the patient is communicating.

**The Relapse Cycle** *(diagram 1)*

![The Relapse Cycle Diagram](image-url)
Chapter II

Theories and Central Concepts

I will here, illuminate and delineate particular theories and concepts that will serve to help understand and interpret the results of this study.

2.1 Definitions of Substance Misuse

According to the World Health Organization (1981), a drug is defined as, “any chemical entity or mixture of entities, other than those required for the maintenance of normal health (like food), the administration of which alters biological function and possibly structure”. A drug, in the broadest sense, is a chemical substance which has an effect on bodily systems and behaviour. A psychoactive drug affects the central nervous system and alters mood, thinking, perception and behaviour. In this context, alcohol is a psychoactive substance. This brings us to the question of misuse. Alcohol misuse, according to the Institute for the Study of Drug Dependence (1996), may be seen understood as the use of drug or alcohol in a harmful or socially unacceptable way. The World Health Organization recommends the use of the following terms:

- Unsanctioned use: a drug that is not approved by society
- Hazardous use: a drug leading to harm or dysfunction
- Dysfunctional use: a drug leading to impaired psychological or social functioning
- Harmful use: a drug that is known to cause tissue damage or psychiatric disorders.

Substance misuse is the result of a psychoactive substance being consumed in a way that it was not intended and which may cause physical, social and psychological harm. It is also used to represent the pattern of use: experimental, recreational and dependent.

Addictive behavior is a complex dynamic behaviour pattern having psychological, physical, social and behavioral components. Dr. G. Alan Marlatt (Rassool, 1988, p.15) defines addiction as:

A repetitive habit pattern that increases the risk of diseases and/or associated personal or social problems. The individual usually has a loss of control, immediate gratification with delayed, deleterious effects, and experiences relapses when trying to quit.

Addictive behavior includes the misuse of psychoactive substances leading to excessive behaviors. Robert West uses a working definition of addiction as simply, “a syndrome in which a reward-seeking behavior has become out of control” (West, 2005, p.10).
**Alcohol Withdrawal Syndrome**

Detoxification is a treatment, usually carried out in a hospital setting, designed to control both medical and psychological complications which may occur temporarily after a period of heavy and sustained alcohol use. The alcohol withdrawal syndrome usually occurs in patients physically dependent on alcohol within 6-24 hours after their last drink and peaks within 24-48 hours. It is characterised by tremors, sweating, nausea, vomiting, restlessness and anxiety and tachycardia. Some patients may experience more serious symptoms such as epileptic seizures. Delirium tremens is a condition where he may become confused and experience hallucinations and is a potentially serious medical condition which can result in death. The symptoms of alcohol withdrawal are self-limiting and usually disappear after 5-7 days (Rassool, 2009).

### 2.2 Addiction Theories

Many models and theories have proposed to explain the use or misuse of alcohol and drugs and the causes of substance abuse. The theories range from those which stress the genetic or biological causes and those which stress social or psychological causes. Some theories attempt to view addiction as both a physiological and a psycho-social phenomenon or a “bio-psychosocial theory” of addiction.

The models or theories provide explanations for the initiation into substance misuse or for why individuals begin to use drugs and alcohol and the process of addiction. Some theories explain both initial and continuing use of drugs. However, the reason why people start using drugs may not be the same reason why they continue to use drugs. It becomes apparent that no single theory is sufficient to explain substance abuse and misuse per se, and that a range of “risk factors” has to be considered. There are a number of theories, but none should be considered to be the definitive account nor is any one theory mutually exclusive of any other.

**Moral Theory**

The moral theory is based on the belief that using alcohol or drugs is a sign of moral weakness or bad character. The individual has deviated from the acceptable religious and social norms. The proponents of this model do not accept that there is any biological basis for addiction. According to the moral theory, individuals are responsible for their behavioural choices and their own recovery. Much of the stigma faced by individuals with an alcohol problem is based on this underlying moral notion that labels anyone with an alcohol problem as a “bad person”. This is where the victim-blaming approach is evident. This model contributes little to our understanding of why people are dependent on alcohol
and has limited therapeutic value. The focus of intervention under this model is the control of behavior through social disapproval, spiritual guidance, moral persuasion or imprisonment (Rassool, 2009).

**Disease Theory**

In contrast with the moral model of “victim-blaming” for the development of addiction, the disease theory of addiction maintains that addiction is a disease due to the impairment of either behavioural or neurochemical processes, or of some combination of the two. This theory views substance misuse as a progressive, incurable disorder and the cause of the disease is firmly attributed to the genetic or biological make up of the individual.

The theory holds that alcohol and drug addiction is a unique, irreversible, and progressive disease and its primary symptom is the inability to control consumption. The concept of “craving” as an “urgent and overpowering desire” defined by Jellinek in 1960, is at the heart of this theory. According to the disease theory of alcoholism, once a drink is taken, “craving” is increased and the physical demand for alcohol overrides any cognitive or voluntary control. Robert West (2005, p.77) eloquently points out:

This theory captures what seems to be the central phenomenology of addiction: a desire that is so strong and all-encompassing that it sweeps all other considerations before it in a myopic and single-minded search for the object of that desire. Even if in some sense there is a choice, it does not seem like it to the addict or to observers, and in the common understanding of the term there is no real choice, there is compulsion.

The proponents of this model hold that, while alcohol cannot be cured, abstinence is the only option. Defining alcohol or drug addiction as a physical or biological disease enables those with alcohol or drug addiction to have access to health care and treatment instead of punitive action or imprisonment. This disease approach implies the adoption of the sick role by the alcohol misuser, and the individuals are expected to be treated as having a “disease”. Spontaneous recovery is unlikely and even with treatment, the potential for relapse is always present. This approach also implies that recovery from alcohol misuse can be sustained only through the goal of total abstinence within support from self-help group movements such as AA (Alcoholics Anonymous). The disease concept of addictive behavior is incorporated in the philosophy underpinning the approaches of AA in the adoption of the “Minnesota Model”. However the disease model of addiction reduces the scope of analysis to features that are physiological in origin and isolates the importance of the interrelationship of both psychological and socio-cultural factors in the maintenance of substance use behaviour (Rassool, 2009).
Genetic Theory

The genetic model presumes that there is a genetic predisposition to alcohol or drug addiction. A number of adoption and twin studies have suggested that alcohol or drug addiction is the result of genetic or induced biological abnormality of a physiological, structural or chemical nature. There is strong evidence that early onset alcoholism is genetically determined. Problem drinkers have a fifty per cent chance of having at least one member of their family becoming dependent on alcohol, and there is a ninety per cent chance of two or more family members being dependent on alcohol (Miller, 2006).

Furthermore, some people may experience a less intense reaction to alcoholic beverages, and such vulnerable individuals drink more before becoming intoxicated. It also appears that a genetic predisposition may also protect some individuals who have a genetically based metabolic sensitivity to indulging in psychoactive substances such as alcohol. One aspect of inheritance is understood amongst members of particular races—Asians for example, are all genetically predisposed to have a deficiency in the production of an enzyme important for alcohol degradation which makes it more difficult to metabolize alcohol, thus causing it to accumulate faster in the system (Miller, 2006).

Studies indicate that alcoholism tends to run in families but acknowledge that no one is clear about what it is that may or may not be transmitted through genetic inheritance. However, when evaluating the pattern of inheritance, all studies showed that it is sons and not daughters who are more at risk of developing an alcohol disorder (Rassool, 2009).

Personality Theory

Within the framework of psychological theories, personality theory stresses the importance of personal traits and characteristics in the formation and maintenance of dependence. Traits such as hyperactivity, sensation-seeking, antisocial behavior and impulsivity have been found to be associated with substance misuse. Although there is an epidemiological association between drug misuse and personality disorder, no deductions can be made about causality as most studies have compared drug-dependent with non-dependent individuals. There might be personality traits which change the likelihood of an individual becoming dependent on drugs (Rassool, 2009).

Psychoanalytic Theory / Psychodynamic Models

Psychoanalytic theory is derived from the work of Freud based on the components of the self and their functioning during the stages of psychosexual development.
Psychodynamic models of mental life focus on dynamic forces. However, certain patterns of mental activity are stable over long periods of time, and the concept of structure has seemed more appropriate than that of force to describe such stable patterns. Motivational systems such as sexuality and aggression, believed by many to stem from the neurobiological organization of the nervous system, are structures. Patterns of defense resulting from innate styles and developmental experiences are also structures.

Freud’s so-called structural model organized mental activity into three overarching structures. One was the id, which referred to organismic and biologically rooted drives and their psychological representations. Second was the ego, which referred to the adaptive and external reality-oriented aspects of the mind, including perception, cognition, memory, motor control and adaptive behavior. Finally, there was the superego, a specialized portion of the ego that tended to function as a coherent, organized system, and that was often in conflict with the rest of the ego as well as with the id. The superego encompasses values and standards, notions of good and bad, right and wrong, approval and disapproval, and the inner source of guilt, shame and pride. The commonsense psychology notion of “conscience” refers to that small aspect of superego functioning that is conscious.

Psychodynamic developmental theory views the primary origin of the superego as the child’s internal psychological representation of the parent-approving and disapproving, loving and criticizing, rewarding and punishing. Guilt is seen as self-directed aggression which can become extremely harsh, threatening or irrational, leading to various affective disorders such as anxiety or depression.

All behavior, according to psychodynamic psychology, including pathological behavior, is seen as adaptive. Instead of being a mistake, pathological behavior involves the effective pursuit of goals concealed both from the patient and from the rest of the world. Such behavior constitutes an adaptive component of an unconscious strategy. The central goal of treatment is to identify the secret goal and bring it out into the open. Psychoanalysis aims to help the client express feelings and urges that have been repressed. By doing so, Freud believed that the client spilled forth the psychic energy that had been repressed by conflicts and guilt. He called this spilling forth catharsis. Catharsis would provide relief by alleviating some of the forces assaulting the ego (Schwartz, 2005).

Freud’s “repetition compulsion” concept deals with the acting out of traumatic repressed events. This phenomenon, which he originally conceived of as a resistance to remembering, was later seen as the result of an attempt to master the original trauma. Traumatic repetitions, if unresolved through therapy, lead to a continual return to the trauma. It is important to note that in the psychodynamic perspective, it is not just the occurrence of a negative life event, but rather the individual’s interpretation of the meaning of the event and its significance.

Freud suggested that the consumption of alcohol provided relief from the psychic conflict between a repressed idea and the defense against it and a deficient ego. Adaptive behavior
requires a harmonious function of the id, ego and superego—the self. Because these components of the self change during the stages of psychosexual development, conflicts can develop, resulting in destructive interactions. Intoxication provides relief from pain or anxiety, intra-psychic conflict and fixation in the infantile past.

Some researchers have observed certain psychodynamic characteristics in substance-dependent individuals. Denzin (2009, p.7), in *The Alcoholic Self* profoundly states:

> Every alcoholic I have ever met drank to escape an inner emptiness of self. This emptiness, often traced to early family experiences of death, parental loss, sexual abuse, drug abuse, or alcoholism, was manifested in terms of a fundamental instability of self. The self-other experiences, the self ideals, and the ideal selves that the alcoholic pursues are largely imaginary and out of touch with the world of the real. Alcohol sustains these imaginary ideals that reflect his unstable inner self.

A main framework for understanding substance abuse emphasizes self-regulatory deficiencies, encompassing deficits in self-care, problems in affect management, narcissism, object relations, and judgement. Because anxieties and distress are relieved by drinking, these individuals may be predisposed to alcohol dependence. Dependency involves the gradual incorporation of the drug or alcohol’s effects and their experienced need into the defensive structure building activity of the ego itself (Frances, 2005). The ego must serve as a signal and guide in protecting the self against realistic external dangers and against instability and chaos in internal emotional life. It follows that many substance abusers, as a consequence of deficits in self-regulation, experience painful and confusing emotions, troubled behaviors, poor self-esteem, stormy relationships or isolated existencies (Lowinson, 2005).

**Social Learning Theory**

This theory, developed by Albert Bandura in the mid-70s, has been extremely influential and has generated much research activity. It describes the effect of cognitive processes on goal-directed behaviour and emphasizes the role of vicarious learning and social environment in the development of alcohol problems. Bandura did not view behavior as actuated from within by psychological or biological drives nor did he view it as controlled only by the external environment. Instead, “human functioning...involves interrelated control systems in which behavior is determined by external stimulus events, by internal processing systems and regulatory codes, and by reinforcing response-feedback systems.” Bandura introduced the idea of *reciprocal determinism*. This meant that behavior may be controlled by the environment, but that behavior may also alter or interact with the environment. For example, the heavy drinker may claim that he drinks excessively in reaction to the feelings that go along with social rejection that is the result of heavy drinking. In 1977, he added the “person”, with self-regulatory functions and self-reflective capability, as a factor in this
model. In this view, the person, the environment, and behaviour are seen as interlocking determinants of each other. The most successful application of this theory has been Marlatt and Gordon’s Social Learning model where reinforcement, cognitive expectancies, modelling, coping and self-efficacy play important roles.

Reinforcement is a central principle of this theory. This learning element is a simple operant response whereby an individual will repeat any behaviour, such as drinking, that leads to a reward (positive reinforcement). He continues to drink because alcohol alleviates experienced anxiety. The more frequent or intense the drinking experience, the more habitual it becomes (Leonard & Blane, 1999)

Individuals also form an expectancy of what they will experience when they drink again. While this expectancy may be confirmed on subsequent occasions, the effects produced are dependent on the amount, as well as factors such as setting (environment/context) and personal characteristics (mood). Expectancies will also be derived on the basis of the presentation of conditioned cues (environmental or internal) that he associates with drinking alcohol. Furthermore, research has shown that expectancies can predict the progression towards alcohol misuse.

The social learning perspective also emphasises the importance of role models. Learning to drink occurs as part of growing up in a particular culture in which the social influences of family, peers and popular media shape the behaviours, expectancies and beliefs of young people concerning alcohol. An important aspect of parental modelling is the development of internalised expectancies for alcohol’s effects. Modelling techniques are even used therapeutically in skills training programs for teaching general and substance-specific coping skills.

Stress can be defined as an “adaptational relationship” between an individual and a situational demand or stressor. Coping is an attempt to restore balance between environmental demands and the individual’s own resources. Problem-focused coping strategies are aimed primarily at directly changing or managing a threatening or harmful stressor while emotion-focused coping is aimed at relieving the emotional impact of a stressor. Since alcohol's effects are often quicker and temporarily effective in dealing with a stressful event than other more beneficial coping responses, alcohol becomes the preferred coping mechanism. These immediate effects of alcohol are, of course, transitory and anxiety may resurface two-fold due to a re-bound effect, the day following a drinking session. This, in turn, leads to an individual becoming increasingly more reliant on using alcohol to reduce anxiety in many situations. He may forget or not be aware of that there other ways of dealing with stress.

Self-efficacy, another key element of social learning theory, is the level of an individual’s confidence in their ability to organize and complete actions that lead to particular goals. Robert West points out that self-efficacy affects the goals that people pursue, the level of
effort used to achieve these goals, as well as how long people will persevere in pursuit of their goals when encountering barriers. It is influenced by the success or failure that an individual has previously experienced. Self-efficacy is not only related to behavior, but to the individual’s “level of perceived control with regard to his thoughts, feelings and environment.” Their confidence that they can cope in a specific situation, and their estimation of the chances of succeeding, will determine the selection and implementation of coping behaviours. The self-efficacy of an individual who has developed a drinking problem following long-term use of alcohol as a way to cope with life’s stressors, is likely to have little confidence in using alternative coping strategies in stressful situations (West, 2005)

As said, social learning theory has generated a good deal of basic and clinical research in the field and helped to form the basis for therapeutic interventions such as coping skills training and cue exposure treatment.

**Socio-cultural theories**

Socio-cultural theories include a number of sub-theories such as systems theory, family interaction theory, anthropological theory, economic theory. In the systems theory, behavior is determined and maintained by the ongoing demands of interpersonal systems in which an individual interacts. The aetiology is based on behavior observed in family contexts such as behavior resulting from the interactions between relevant significant others. Steinglass’s (1987) work supports the idea of alcoholism as a “family disorder”. In the family interaction theory, the most significant factor is probably parental deficits that occur as a product of parental alcoholism. These deficits may include parental absence, family tension, rejection, emotional distancing and parental alienation. There is also some evidence to suggest that alcohol may serve as an adaptive function in a marital relationship by facilitation of interaction.

The cultural model also recognizes that the influence of culture is a strong determinant of whether or not individuals fall prey to certain addictions. Cultural and religious attitudes have been considered to be a defensive shield against alcohol and drug addiction. For example, the uses of moderate or controlled drinking within the family setup have an influence on the drinking behavior of their children. This perception tends to encourage individuals to view alcohol as a social lubricant with clearly defined social rules and etiquette.

Other socio-cultural factors that may have an influence on the choice of alcohol use and misuse include gender, age, occupation, social class, ethno-cultural background, subcultures, alienated groups, family dysfunction and religious affiliation.
Bio-psychosocial theory

Many models of addiction could be criticised for failing to attend sufficiently to social and environmental factors. There have been several attempts to amalgamate the biological, psychological and sociological theories of drug and alcohol addiction into a megatheory. Even though the focus here is on biological and psychological processes, social factors are also included in this model through learning, perceiving and interpreting the world about us as well as through the person’s social relationships and larger cultural environment.

The bio-psychosocial model takes into consideration a broad range of factors which interact resulting in addiction. Thus, drug and alcohol addiction are viewed as the result of multi-factorial causation rather than having a uni-dimensional cause. By adopting a holistic, multi-dimensional approach, the bio-psychosocial theory has provided a new conception of alcohol and drug misuse that focuses attention towards a new set of questions about the nature and process of addiction (Rassool, 2009).

2.3 Ritual Theories

Psychoanalytic Approaches to Ritual

Psychoanalysis and myth and ritual theory greatly influenced each other. Sigmund Freud was influenced by Sir James Frazer’s theory of religion that relied heavily on psychological elements. It suggested that “primitive” peoples developed religion to explain and rationalize perplexing psychological experiences having to do with dreams, nature, and the effectiveness of magic. For Freud, the neurotic’s obsessive activities, as well as the anxiety and guilt that accompany these acts, imply a similarity between the causes of religion and the causes of obsessional neuroses. He suggested that both are rooted in the same psychological mechanisms of repression and displacement. Freud states:

We cannot get away from the impression that patients are making, in an asocial manner, the same attempts at a solution of their conflicts and an appeasement of their urgent desires which, when carried out in a manner acceptable to a large number of persons, are called poetry, religion and philosophy.

According to Freud, rituals are an obsessive mechanism that tries to assuage repressed and tabooed desires in an attempt to solve the internal psychic conflicts that these desires cause (Bell, 1997, p. 13).

A few theorists have found a more positive interpretation of ritual from Freud’s writings. Volney Gay interpreted ritual behavior by explaining, “it is a product of the non-pathological, often beneficial, mechanism of suppression—not repression” (Bell, 1997, p.15). As such,
“rituals might to the degree that they aid the ego’s attempt to suppress disruptive or dangerous id impulses, further the cause of adaptation.” Theodor Reik (1888-1969) applied Freud’s early psychoanalytic principles to various forms of ritual and saw the significance of the information that could be gleaned from people’s activities apart from their own verbal (mythic) account. Catherine Bell (1997) formulates these ideas so well when she explains:

Methodologically, psychoanalytic ethnographers might begin with the ritual, but they must work backward, even past the etiologic myth, to uncover what is thought to be the “real” story of desire and repression, fear, and projection that is at the root. Unconscious motives are the profoundest and most explanatory; the unconscious myth is the true one. Explanation to uncover the true myth will uncover the meaning of the ritual in what Freud called the “return of the repressed” (Bell, 1997, p. 15).

**Ritual Sequence**

Rituals have a form and a determined course. They are composed by metaphors, symbols and actions that are packaged in a highly condensed dramatic form. Rituals involve unique staging: preparation, enactment, and a return to normal. They provide an orientation to action and hence a framing of action that is relevant in understanding human activities. Broadly defined, ritual is the “voluntary performance of appropriately patterned behavior to symbolically affect or participate in the serious life” (Rothenbuhler, 1998, p.27).

Three stages have been identified that are important to the ritual process. Stage one is a separation stage at which time the individual prepares for the ritual and separates from everyday routine. Stage two is transitional, where the individual encounters the ritual and explores new roles and identities. Reintegration is the third stage that moves the participant back into everyday experience. Generally, rituals are composed of both open and closed elements. Open elements allow individuals some flexibility to attach their own meanings to the ritual. Participants are allowed to create or add to its content (Imber-Black & Roberts, 1988).

**Social functions**

It seems that the social functions that rituals serve are endless but they can be grouped into three categories: an ordering function, a community function and a transformation function. Ritual has a power to order life—it sets up routines and helps us to share perceptions. It gives us a sense of stability and continuity and even helps to restore order when it has been lost. We are also brought together and united emotionally through the group ritual. Though feelings may be ambivalent within the group, ritual helps guide and control our emotions.
And most importantly, ritual processes facilitate various kinds of transformation. Ritual events *change* things – when the king is anointed, the couple wedded, the prayer whispered or the concert hall rocked by the audience, we have instances of transformation. Victor Turner believes that this “social magic” of rituals and their character as “transformative performance” is a result of their power to envision a reordering of the world. Tom Driver eloquently explains that the performance of ritual “brings the far-away, the long-ago, and the not-yet into the here-and-now.” And because it is performance, ritual produces its effects not simply in the minds but in the bodies of its performers (Driver, 1998, p.167).

Rituals are deeply rooted in our animal natures. What goes on in churches, ceremonies, feasts, weddings, etc. is built upon an urge to ritualize what we share with other animals that has been part of our makeup since long before we evolved into our present form. We share a communicative world of highly patterned behaviors. Animals need this behavior to communicate and it is in our ritual behaviors that we find the similarity. Rituals have the power to integrate our most “advanced” ideas and aspirations with some of our most “primitive” tendencies. Tom Driver explains, “Human beings, like other animals, and for many of the same reasons, engage in ritual. We need them to give stability to our behaviors and to serve as vehicles of communication” (Driver, 1998, p.169).

Rituals are the first symbols, carrying within themselves, just as words will later do, a whole complex of meanings. Patterned and repetitive behavior can be used to store and transmit information across time and across generations. The mode of transmission is clearly cultural. Driver (1998, p.27) goes on to say:

In human culture, the sense of ritual as ritual, that which makes it recognizable and intelligible as human behavior, presupposes a gestural context that goes beyond all formal ritual. No matter how symbolic human rituals may be, their sense requires the pre-understanding of a ‘world’ in which the members of a group can communicate with each other through patterns of behavior. Language itself is made up of patterned behavior, some of it audible, some gestural, and some a combination.

Actions, so the saying goes, speak louder than words. Ludvig Wittgenstein emphasizes, “... it is our *acting*, which lies at the bottom of the language-game” (Driver, 1998, p. 200).
Ritual Qualities

It is clear that ritual studies pay primary attention to performance, enactment, and other forms of overt gestural activity. Ronald Grimes (1990) takes up the terminological division between “rite,” “ritual,” “ritualizing,” and “ritualization.” The term “rite” denotes specific enactments located in concrete times and places and is differentiated from ordinary behavior. A “ritual”, on the other hand, is a much broader idea and used in formal definitions and characterizations. The word “ritualizing” refers to the act of cultivating or inventing rites. Ritualizing suggests a process or a quality of emergence. Unlike many scholars who seem to identify ritual only with its religious form, Grimes distinguishes at least three ritual levels based on the degree to which they are differentiated from ordinary action: ritualization, interaction ritual and liturgy. He further explains that ritualizing is not often socially supported but rather happens in the margins and on the thresholds. It refers to activity that is not culturally framed as ritual but might be interpreted as such— it is “pre-ritualistic”. Ritualization is the least differentiated kind of ritual and because of its low degree of formalization, is most likely to go unnoticed. But Grimes takes ritualization every bit as seriously as liturgy as it is rooted in our own biorhythms and psychosomatic patterning. Ritualization runs deep.

Grimes goes on to explain that the notion of ritualization invokes metaphor. Although ritualization includes processes that fall below the threshold of social recognition, we “see” ritual and various types of rites as “there”. Our cultural consensus recognizes these activities. Grimes points out that social drama and ritualization are deeply embedded in ordinary human action and go on all the time in our daily lives. On occasion we focus and concentrate these processes and produce a drama and rite respectively.

Because there is no cultural consensus that defines everyday activities as ritual, Grimes employs the strategy of dividing ritual into “hard”, discrete sense (rites) on the one hand, and “soft”, metaphoric sense (ritualization), on the other. Grimes’ tactic serves to clarify these ideas thus allowing for study of mixed genres- such as ritual drama and activities that fall on the borderlines of the usual categories. In this way, the problem of cultural consensus is avoided.

Although an adequate definition of ritual is difficult to grasp, I found Ronald Grimes’ approach to understanding the nature of ritual very helpful for this paper. He identifies certain “family characteristics” which show up in specific instances. This not only keeps us from thinking of activities as if they either are or are not ritual but allows us to specify in what respects and to what extent an action is ritualized. “Any action can be ritualized,” he points out, “though not every action is a rite.” Grimes emphasizes that ritual is a quality and that there are “degrees” of it (Grimes, 1990, p.13).
The following is a list of qualities that appear frequently in the family of ritual activity:

- performed, embodied, enacted, gestural (not merely thought or said)
- formalized, elevated, stylized, differentiated (not ordinary, unadorned, or undifferentiated)
- repetitive, redundant, rhythmic (not singular or once-for-all)
- patterned, invariant, standardized, stereotyped, ordered, rehearsed (not improvised, idiosyncratic, or spontaneous)
- valued highly or ultimately, deeply felt, sentiment-laden, meaningful, serious (not trivial or shallow)
- condensed, multi-layered (not obvious, requiring interpretation)
- symbolic, referential (not merely technological or primarily means-end oriented)
- perfected, idealized, pure, ideal (not conflictual or subject to criticism and failure)
- dramatic, ludic (i.e. playlike) (not primarily discursive or explanatory; not without special framing or boundaries)
- paradigmatic (not ineffectual in modelling either other rites or non-ritualized action)
- mystical, transcendent, religious, cosmic (not secular or merely empirical)
- adaptive, functional (not obsessionial, neurotic, dysfunctional)
- conscious, deliberate (not unconscious or preconscious)

Grimes points out that no single one of these qualities is definitive of ritual—nor is any single quality unique. However, when these qualities begin to multiply, it becomes clear that an activity is indeed “ritualized” (Grimes, 1990, p.14).

**Metaphor**

In ritual studies we try to understand metaphors on the basis of which people act, especially those they repeatedly act out or elevate to the status of gesture. A metaphor is a drastic symbolic act. In a metaphor this is perceived as that: the bread is the body, the heart is the person and so on. A metaphor is powerful because it is not the sort of symbol that merely points or refers to some abstract idea. Grimes points out that a metaphor *embodies* what it means. If one’s means of symbolizing is one’s own body rather than say, a word, a picture, or an object, the possibilities for “becoming what one beholds”, to invoke William Blake, are much greater. Hence it is useful to regard ritualized symbols as metaphoric, because of the degree to which the symbolic vehicle and the thing symbolized become identified in metaphor (Grimes, 1990).
Because the notion of “illness” shows itself to be prominent in the results of my study, I responded to Grimes’ explanation of the somatic metaphor. Alcoholism is often explained as, or given the “disease” metaphor. He explains (1990, p.149):

If patients are diseased, they will be so diagnosed only if they display the symptoms, a ritualized process. On the other hand, if they play-act the metaphors of illness, they run the risk of evoking a disease. Though we can distinguish them, we can never ultimately separate physiological disease and symbolic illness. They are systematically related; a change in one usually precipitates variation in the other. Metaphors are not merely decorative or literary embellishment. If we express and evoke disease by taking on the postures and gestures of illness, we regain health by embodying other metaphors. Contrary to Sontag, Illich, and Szasz, I do not believe we escape metaphors, myths and rituals; we only change them.

Performance

The activity of ritualizing became the pathway to the human condition. Ritualization is an experiential way of going from the disconnected to the expressive. And in humans, it is closely linked to the performing arts as well as being a precursor to speech, religion, culture and ethics (Driver, 1998). In the mid-1970s, a number of ideas came together to yield a “performance approach” to the study of ritual—Kenneth Burke, Victor Turner and Erving Goffman were major contributors. Although ritual theorists had long argued that theater emerged from ritual, performance theorists tend to see more of a “two-way street”. Performance models suggest active rather than passive roles for ritual participants who re-interpret value-laden symbols as they communicate them. It is a dynamic process that emphasizes human creativity and physicality (Bell, 1997). Driver (1998, p. 25) states, “It is not as true to say that we human beings invented rituals as that rituals have invented us”.

In performance we find something quite basic about human beings - that we constitute ourselves though our actions. But there is something inherently ambiguous in the idea of “acting” or “performing”. Ritual action is different from ordinary life as it moves in a kind of “liminal” space, at the edge of “the real world”. Anthropologist Victor Turner made this concept prominent. One of the characteristics of liminal activities is that they are regarded as performances - in other words, there is something about them that is “put on”. On the one hand these activities mean “to do”, while on the other, they mean “to pretend”. Human beings are indeed very good actors. But there are many situations in which the doer is his own spectator and makes the performance for himself, or for an ideal spectator who is not visible. Performance, then, is a highly complex social, psychological and moral phenomenon and may be defined simply as that kind of doing in which the observation of the deed is an essential part of its doing, even if the observer be invisible or is the performer himself.
Human beings have great freedom in their capacity to transcend an immediate situation because they not only act but know they are acting. They can do one thing while pretending another. A performance involves both the body and the mind and takes place in an environment that is both actual and imaginary. Performance is the unity of doing and observing (Driver, 1998).

It is in this ritual mode of performance that we see the performer assuming roles and relating to what is going on in an “as if” way not appropriate to the workaday world. There is a quality of playfulness in rituals where the gestures serve to communicate, entertain, and invoke something or someone not otherwise present in the work itself. They are a sort of “playful work” charged with energies and meanings. As work done playfully, ritual remains in touch with what is “other”. Ritual is not about itself but about relation to “not-self.” It is concerned with powers that are understood to have their being outside the ritualizers, even though it is ritual that gives these powers their being, instantiating them with its “circle of magic.” Driver (1998, p. 198) points out:

The serious must play if ritual is to be capable of any lasting transformations. The transformative work accomplished through play cannot be accounted for rationally. As long as we remain within the mode of performance, any and all things are possible - that which could be, what might be, and ought or ought not to be, are revived in adults and given permission to happen in the pretend time of the ritual occasion.

When people engage in ritual activity, they separate themselves, partially, if not totally, from the roles and statuses they have in the everyday world. A threshold in time and space or both develops and certainly demarcations of behaviour over which people pass, when entering into a ritual. The day-to-day world is temporarily suspended as he enters the state of being neither here nor there but “in-between.” The time of ritual and existing in a subjunctive mode of play and pretend is only for a limited time and when it is over, the everyday duties must resume (Driver, 1998).

Another important concept in performance theory is “framing” or context. As first used by Gregory Bateson, the term indicates the way in which some activities or messages set up an interpretive framework within which to understand other subsequent or simultaneous messages. Frames, for Bateson, are a form of “meta-communication.” For example, framing enables one monkey or even children for that matter, to hit another and have it understood as playing—not fighting. Play, Bateson argues, can only occur if the participants are capable of some degree of meta-communication (Bell, 1997).

As said, without this quasi-theatricality of display, ritual’s communicative and symbolic functions could not exist. Moreover, ritualization is a holistic process. Richard Comstock explains, “there are no isolated emotions causing ritual behavior...what must be stressed is the synchronic interaction of feeling, thought and bodily movement in their concrete unity.”
But the dominant functions have to do with efficacy and with bringing about some sort of change. Schechner uses the term “transformances”, meaning performances that are “the means of transformation from one status, identity, or situation to another” (Driver, 1998, p. 201).

**Religion**

Catherine Bell takes up myth, ritual and the phenomenological approach to religion in her writings. She explains the ideas of Mircea Eliade (1907-1986) which argue that rites are re-enactments of the deeds performed by the gods in the primordial past and preserved in mythological accounts. By performing these deeds again in ritual, the participants identify the historical here and now with the sacred primordial period of the gods before time began. Through the ritual enactment of primordial events, according to Eliade, human beings come to consider themselves truly human, sanctify the world, and render meaningful the activities of their lives. The meaning of sacrificial offerings and practices that associate sexuality and fertility lay in the fact that these acts specifically repeat the mythical activities that created the cosmos: “The ritual makes creation over again.” His focus on the relationship of ritual to the cosmic myth heavily evoked themes of death and rebirth, degenerative chaos and regenerative order (Bell, 1997).

Jonathan Z. Smith (b. 1938) takes these ideas of religious ritual and practice and points to how historically specific rituals attempt to create broad patterns of order and meaning. Simply stated, ritual portrays the idealized way that things in this world should be organized, although we are well aware that real life keeps threatening to collapse into chaos and meaninglessness. Smith suggests that ritual is an opportunity to reflect on the disjuncture between what is and what ought to be; it is a “focusing lens” through which people can attempt to see, or argue for, what is significant in real life (Bell, 1997). Smith defines ritual as “a means of performing the way things ought to be in such a way that this ritualized perfection is recollected in the ordinary, uncontrolled, course of things” (Grimes, 1990, p. 165).

**Ritual and Communication**

Every instance of communication is obviously a combination of the ideal and the material, the individual and the collective. For anything to count as communication, there must be about it some properties attributable to ideas (meanings, emotions, elements of internal experience) put in material form (written, spoken, externalized) by some individual (action taken for a purpose) in an order understandable by others (with a syntax, semantics, and pragmatics we can share, according to a sign system common to a group). Ritual is different from ordinary behavior because it signifies meaning beyond the behavior itself. There are
many important implications of the communicative nature of ritual; a general one is that we should expect that rituals work in the way that communication works. In other words, it is subject to unpredictable variations, of interpretation, bias and understanding. And it must be interpreted before it can have effect (Rothenbuhler, 1998).

2.4 Communication Theory

Communication theory does not refer to any single theory but rather “can be used to designate the collective wisdom found in the entire body of theories related to the communication process” (Littlejohn, 1996, p.14). Theories of communication developed between the late 1940s and 1960s and, as explained earlier in the Shannon and Weaver model, embraced a linear design where messages and information are transmitted from a source to a receiver. This group of theories, making up the relational view of communication, leans toward a process model that portrays communication as ongoing, dynamic and reflexive, as opposed to static and linear (Rasheed, 2010).

The core assumptions of relational theory are twofold. First, all messages have two levels: a content level (which involves the literal interpretation of discourse) and a relationship level (which provides information about how the content message should be classified). The second assumption postulates that relationships can be categorized in two predominant ways: a symmetrical relationship characterized by similarity in message exchange (e.g. boasting followed by boasting) or a complementary relationship characterized by difference (e.g. boasting followed by passivity). This view applies the premises of systems theory, which posits that the whole is considered greater than the sum of its individual parts, to human communication, and the ideas of psychologist Jurgen Reusch and anthropologist Gregory Bateson (Rasheed, 2010).

Family therapy was influenced in the 1940s and early 1950s by the development of cybernetics, systems, and communication theory. These theories, influenced by concepts from multiple disciplines including sociology, anthropology and biology, provided powerful theoretical frameworks for deeper understanding of the complexities of family interaction. They also allowed researchers to free themselves from psychoanalytic formulations for understanding emotional disorders such as schizophrenia and to expand their understanding of these disorders as a function of disturbed relational and communication patterns within families. Cybernetics, systems and communication theory acknowledged that an individual’s behavior is not determined solely by one’s internal world but that the social context is a powerful determinant in shaping behavior. Individual psychopathology cannot be
understood without an appreciation of the psychosocial context of the individual and his family.

During the 1940s and 1950s an interdisciplinary group including mathematicians, physicists, biologists, engineers, psychologists, cultural anthropologists, and sociologists began to look at inanimate, organic and human organizations and structures as a complex arrangement of component parts and interacting elements. Together, these elements form interdependent entities that these theorists labelled as “systems”. It was primarily through the works of biologist Ludwig von Bertalanffy, considered the father of general systems theory and Norbert Wiener, who coined the term “cybernetics” that these elements were understood as sharing certain characteristics that allowed them to function as systems.

As general systems theory describes the structural aspects of systems, cybernetics illustrates the functioning of systems. Systems theory aims to integrate knowledge into a realistic and clear framework and emphasizes the relationships between system members. Structurally these interdependent entities or “systems” are composed of interrelated parts (subsystems) that constitute an ordered whole with each part of the system impacting all other parts as well as the system as a whole. Functionally, systems have a quality of self-organizing through the process of establishing feedback mechanisms, either positive or negative, by which they are able to maintain a sense of homeostasis or equilibrium. Negative feedback characterizes homeostasis and therefore plays an important role in achieving and maintaining the stability of relationships. Positive feedback, on the other hand, leads to change, i.e., the loss of stability or change. In this way a system, through its own information processing system, is allowed to reinsert into its structure the results of its past performance or output in order to alter its functioning. Causality becomes thus, non-linear and more circular. It is understood that forces do not simply move in one direction in which each event is caused by a previous event. Rather, seemingly small events become part of a causal chain with each event both influencing and being influenced by other events in a non-linear manner. In this way, the systems perspective makes it possible to examine and explore how the individual both influences and is influenced by the dynamics within the family system (www.vonglasersfeld.com).

Interpersonal communication systems theory addresses the interactional patterns reflected in the processing of information within the system. These patterns within the larger system such as a family shape the function of the system. From a systems perspective, human communication is not a one-way process but rather a multidirectional phenomenon with no distinguishable beginning or end. Control over the communication process is shared among the members of the interpersonal system rather than held in the hands of the sender (Rasheed, 2010).

Systems theory was fundamental in the development of the relational model of communication by the Palo Alto research group that included Bateson, Watzlawick and Jackson. They conceptualized the communication process as an open system. They
regarded the context of a communication act as extremely important because open systems interact with the environment. Environments affect the systems that interact with them and are, in turn, affected by those systems. As an interpersonal system changes in response to the environment or to changes within system members, the context of the message also changes. Messages, in the systems view, have no fixed meanings but are given meaning from the context in which they exist.

The relational model proposed by the “pragmatists” or Palo Alto group is concerned with both the effect of communication on the receiver and the effect the receiver’s reaction has on the sender. In the interactive communication process, focus is on the sender-receiver relationship.

As said, first order cybernetics is the science of observed systems where the observer remains outside the system; second order cybernetics, developed in the 70s by Heinz von Foerster, is the science of observing systems where the observer is part of the system.

First order change refers to change within a given system. In other words, the system itself remains unchanged, while its elements or parts undergo some kind of change. First order change appears to be linear. It is a change in quantity, not quality and it involves using the same problem-solving strategies over and over again. Each new problem is approached mechanically. If the problem resists resolution, more old strategies are used and are usually more vigorously applied.

Second order change refers to a change in the system itself. The system is transformed through structure or communication. Second order change tends to be sudden and radical, and brings the system to a different level of functioning. The aim is to enable the individual to behave, feel or think differently (Littlejohn, 1996).

Watzlawick, Beavin and Jackson’s (1967) Pragmatics of Human Communication has provided the foundation for a tremendous amount of interpersonal communication research in this area. It deals with behavioral or “pragmatic” effects of communication and identifies five simple properties or “axioms” of human interaction.

- **One Cannot Not Communicate:** interpersonal communication occurs on multiple levels including verbal and non-verbal. All behavior in an interactional situation has message value, i.e., is communication. Activity or inactivity, words or silence all have message value: they influence others and these others, in turn, cannot *not* respond to these communications and are thus themselves communicating.

- **Human Beings Communicate both Digitally and Analogically:** digital communication “refers to things by name” (language) whereas analogical communication “represents things by likeness” (tone of voice, facial expression etc.).

- **Communication Equals Both Content and the Relationship:** the latter shapes and provides the context that surrounds the former which ultimately impacts the
interpretation. Thus, every communication has dual dimensions: content/report and relationship/command. The relationship level influences meta-communication. Watzlawick et al. explain:

The report aspect of a message conveys information and is, therefore, synonymous in human communication with the content of the message—the command or “framing” aspect, on the other hand, refers to what sort of a message it is to be taken as, and, ultimately the relationship between the communicants. All such relationship statements are about one or several of the following assertions: ‘This is how I see myself…this is how I see you…this is how I see you seeing me…’ and so forth in theoretically infinite regress.

• **The Nature of the Relationship Depends on How Both Parties Punctuate the Communication Sequence**: communication patterns occur within the context of dynamic and interactive relationships, i.e. “circular causality”.

• **All Communication Is Either Symmetrical or Complementary**: similarities or differences in power, control or status exist within the relationship. Symmetrical communication is based on equal power while complementary communication is based on a differential in power. (Watzlawick et al., 1967)

Every theory of communication is another level of communication—a meta-communication—and is itself a created reality. The pragmatic perspective of human communication is certainly no exception.

Objective reality exists independently of we who observe it. The logical imperative for the psychologist is to account for how we perceive and know about such a world. Paradoxically, grasping the limits of our own understanding can free us to live more creative and meaningful personal and professional lives (Littlejohn, 1996).
Chapter III

Case Study Method

3.1 Method

Case studies are widely used in organizational studies and across the social sciences. Case study research consists of a detailed investigation of phenomena within their context. The aim is to understand how behaviour and/or processes are influenced by, and influence context and to provide an analysis of the social context and processes which illuminate the theoretical issues being studied. The case study is particularly suited to research questions which require detailed understanding of processes because of the rich data collected in context.

The case study is not as much a method as a research strategy with the context as part of the design. As such, there will always be too many ‘variables’ for the number of observations made and so the application of standard experimental or survey designs is not appropriate. Within this broad strategy, qualitative, quantitative or multiple methods may be used. Participant observation, direct observation, interviews (semi-structured to relatively unstructured), focus groups and questionnaires may be used separately or in combination. A combination of methods not only helps improve validity (by ‘triangulating’ data and theory) but may also be the best way to approach complex phenomena (Yin, 2009).

A case study must be defined in terms of its theoretical orientation which places emphasis on understanding of processes alongside their contexts. The value of theory is of utmost importance. Although the study may begin with only a rudimentary theory, the researcher needs to develop theoretical frameworks during the course of the research which inform and make sense of the data and which can be systematically examined during the case study for plausibility. The theory must provide not only a sense of the particular circumstances of the case but also what is of more general interest and relevance.

Case study design is flexible in that it is able to adapt and probe both areas of planned and emergent theory. Theory development can occur through the systematic piecing together of detailed evidence to generate (or replicate) theories of broader interest. Robert Yin suggests that the method likens the role of the detective who must sift through evidence, relevant and non-relevant; to build inferences about what has happened, why and in what circumstances. This is done, not only to understand the particular features of the case(s) but also to draw out an analysis which may be applicable on a wider basis (Cassell, 2004).

A research case study aims to examine research questions and issues, by setting these in a contextual and causal context. Yin notes that a high quality case study is characterized by rigorous thinking, sufficient presentation of evidence to reach appropriate conclusions, and careful consideration of alternative explanations of the evidence. It is important to have a
thorough approach to the research design, the formulation of research questions and data collection. Robert Stake notes: “Most researchers find that they do their best work by being thoroughly prepared to concentrate on a few things, yet ready for unanticipated happenings that reveal the nature of the case” (Stake, 1995, p. 324).

I have chosen the case study as a method for investigating and explaining the phenomenon of the alcohol “relapse”. As a research method, the case study method allows the study to retain the holistic and meaningful characteristics of real-life events. Its strength is in its ability to deal with a variety of evidence. Another advantage to the case study method is in its logic of design - it not only deals with real- life phenomena but also with important contextual conditions (focus on contemporary conditions). My research relies on interviews of the persons involved. Because my research questions are more explanatory in that they pertain to the “how” and “why” of the phenomenon, as well as the need for focus on a contemporary event without the need for control, the case study method was the most advantageous choice (Yin, 2009).

The research design is the logical sequence that connects the data to be collected to the study’s initial research questions and ultimately to its conclusions. It is a guide in the process of collecting, analyzing and interpreting observations. Case study research designs are composed of five parts: study questions (in this case, in the form of “how” and “why”); study propositions (relapse behavior); unit(s) of analysis (case studies of clinical patients with experience of relapse); the logic linking the data to the propositions and criteria for interpreting the findings (pattern- matching, explanation building, logic models).

The role of theory development as part of the design phase is essential. Robert Yin explains that it is also important to have a ‘rival’ theory- one that can cover all five parts of the complete research design. In this way one can anticipate, identify and address rival explanations for the findings. This blueprint will give a stronger design and help with the interpretation of data. Theory development does not only facilitate the data collection phase, but also at the level of which the generalization of the results will occur (Yin, 2009).

Evidence from multiple cases is often considered more compelling and the overall study is therefore regarded as being more robust. Multiple-case studies follow a “replication” design. Replication logic goes hand in hand with the development of a rich, theoretical framework. The framework states the conditions under which a particular phenomenon is likely to be found as well as the conditions when it is not likely to be found (theoretical replication). Thus, the theoretical framework becomes the vehicle for generalizing to new cases (similar to cross experimental designs). Again, if some of the cases do not work as predicted, theory modification must be made. Multiple case results should be the focus of a summary report which indicates how and why a proposition was or was not demonstrated. Across cases, the report should indicate the extent of the replication logic and why certain cases were to have certain results and other cases, contrasting results. It is sometimes necessary to modify or redesign during the course of investigation. For example, an
important discovery, which doesn’t fit the original design, may occur during the course of the interview of one of the cases (Yin, 2009).

Case study evidence may come from the following sources: documents, archival records, interviews, direct observation, participant-observation, and physical artifacts but throughout, a major objective is to collect data about actual human events and behaviour. One of the most important sources of case study information is the interview as it provides important insights and helps to identify other relevant sources of evidence. Various interview types are ‘depth’, ‘exploratory’, ‘semi-structured’ or ‘unstructured’. Kvale defines the qualitative research interview as “an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena” (Kvale, 1983, p. 174). The goal of the qualitative research interview is to see the research topic from the perspective of the interviewee, and to understand how and why they come to have this particular perspective. To meet this goal, qualitative research interviews will generally have a low degree of structure by the interviewer, a high degree of open questions and a focus on “specific situations and action sequences in the world of the interviewee” (Kvale, 1983, p.176) rather than abstractions and general opinions.

Inter-personal processes play a major part in the course of the qualitative research interview. The relationship between interviewer and interviewee is part of the research process and not a distraction from it as it might be in other methods such as a questionnaire or experiment. The interviewee participates and actively shapes the course of the interview rather than passively responding to pre-set questions (Cassell, 2004).

Data collection procedures for the case study interview are not routinized but Yin suggests that the interviewer have certain skills—he should ask “good questions” throughout the data collection process in order to create a rich dialogue; he must be a “good listener” and make keen observations that capture mood, affective components and understanding of context; he must be adaptive and flexible and open to new opportunities; he must understand the issues being studied in order to be able to grasp relevant events and information and he must be unbiased by preconceived notions (Yin, 2009, p.72).

As the interview is more of a guided conversation than a structured inquiry, the interviewer is required throughout the interview, to operate on two levels simultaneously. ‘Level 2’ questions deal with satisfying the needs of the line of inquiry in terms of theory and rival theory while open-ended ‘level 1’ questions aim towards the case study findings (Yin, 2009).

I chose the “semi-structured” interview as instrument for my research. In this type of case study interview the individual is interviewed for a short period of time. Though the questioning remains open-ended and assumes a conversational manner, I was able to follow a certain set of questions derived from the case study protocol (Yin, 2009).
3.2 Sample

I received permission to conduct patient interviews from my supervisor. Subjects were selected through my place of work at the Clinic. I sought after patients who have both a history of alcohol abuse and experience with repeated alcohol relapse. I deliberately chose not to select any of my own patients, past or present, and relied instead on my colleagues for suggestions for subject selection. I wanted to proceed into the interview situation with an open mind with individuals I had never before met. My colleagues were briefly informed about the subject matter of the interview, i.e. “alcohol relapse”, and as to the criteria I was seeking without my going into detail. I wanted to make sure that the interviews retained a quality of spontaneity and that my colleagues did not unintentionally influence the subjects in any way. I wanted to be disarmed and surprised and I wanted stories that provided new insights and vistas. I prepared myself for the difficult task of ridding myself of preconceived expectations.

Kvale recommends that one interview as many subjects as necessary in order to find what one needs to know. I decided to heed his advice and concentrate on at least five intensive case studies. As the sample size followed the concept of “saturation” as a guide, I felt that any further collection of new data would not shed any new light on the study. All in all, six interviews were conducted but during the course of the last interview, it became apparent that the subject did not fulfil the criteria of experience with alcohol relapse and for this reason will not be included in the results analysis. I chose not to take up the matter with him and instead, thanked him for his time.

I was introduced to the subjects through four of my colleagues and we decided to meet, at their convenience, in my room at the Clinic. They were informed about the purpose and procedure of the interview. I also explained that information and tape recordings would be handled confidentially. I pointed out that they were free to choose not to answer certain questions. Subjects were also given a chance to ask their own questions in a de-briefing which took place after the interview. I offered to contact them after the study was completed to discuss the results and all readily accepted.
3.3 Data Collection

I began the interview with an open question designed to obtain a good narrative and to allow the subject to speak freely:

‘I would like to follow you on your journey into relapse-while on your way into the relapse; what happens when you’re there; and on your way out. I want to understand.’

Prepared notes with both direct and indirect questions to be asked during the interview were also used (shown in the appendix). I wanted to make sure that I kept “on track” and did not forget any important questioning. These notes and questions were revised as the interviews proceeded. New ideas and aspects came into light but major changes in design were not necessary.

Despite my experience in listening to others, the interview situation brought with it new challenges. During the interview, I wanted to make sure that my line of questioning was directed towards my main research questions and that I didn’t miss important themes. Not only this, but I was also required to pose individual questions to each interviewee. There were after all, two levels of inquiry to be dealt with simultaneously—i.e. “Level 1” and “Level 2” questions. I also wanted to be sure that the research interview wasn’t transformed into a therapeutic interview which was yet another reason for not choosing my own patients. There were instances where I found it difficult to steer the interview because the interviewee did not contain himself to the relapse story. In these cases, I relied on the communication model, as described earlier. I used the model’s linear structure, with its beginning, middle and end, as a reference point for both myself and the interviewee. Also, I found that by taping the interview, instead of taking notes, I could concentrate closely on listening to, maintaining eye contact and observing the interviewee.

I listened to each full tape recording as soon as possible afterwards and made many notes. I did not find it difficult to construct a condensed, narrative version, including direct quotes, of the hour-long interview onto two pages of text. I do believe that meanings were shaped in the context of the exchange and I was able to analyze much of the interview, as Kvale describes, “by the time the tape recorder was turned off”.

I chose the analytic technique of pattern-matching, where patterns and themes are compared with those which have been predicted. If patterns coincide, the results can strengthen the case study’s internal validity. I did indeed find many patterns and themes which supported the expected pattern or hypothesis. Certainly elements of control and dramaturgy were evident but many other very interesting patterns began to appear.

Miles and Huberman (1994, p.254) point out that comparison is a classic way to test a conclusion and a tactic that sharpens understanding— it is “the method of differences”. I wanted also, in my report, to give a contrasting picture of the interviewee as he is normally—i.e. when not in relapse mode. It strengthens the idea of the “relapse” sequence as a very
distinct phenomenon and far removed from ordinary day-to-day life. I also included several control questions in my notes that helped with interpreting information.

3.4 Validity

Validity tests are used to gauge the quality of research designs. Specific concepts must be adequately defined and citing published studies that match concept are a minimal requirement for meeting “construct validity”. “Internal validity” deals with making inferences. Because events cannot be directly observed in case study research this can be a concern. Analytic tactics such as pattern-matching, explanation building, addressing rival explanations and logic models can help strengthen internal validity. “External validity”, in case studies, deals with striving to generalize a set of results to a broader theory. It should help in identifying yet other cases to which the results are generalizable. “Reliability” deals with the adequate documentation of procedures to minimize biases and errors (Yin, 2009).

I have chosen the multiple-case design, as opposed to the single-case design with thought to the mode of analytic generalization. Simply stated, if two or more cases are shown to support the same theory, replication may be claimed. In this way the empirical results may be considered yet more potent if two or more cases support the same theory but do not support an equally plausible, rival theory.

I used the tactic of “member-checking” as a way in which to improve validity of the study. During the interview process, I paraphrased and summarized information given. In this way, the interviewee could affirm that the summaries accurately reflected their views, feelings and experiences. By re-stating and summarizing, the interviewee was not only given a chance to expand and elaborate on what had been said, but helped the interview situation become more lively and fluid. I found my interviewing skills improving with each new interview experience.

I intend to meet with the subjects again and present them with the data and finished results of the study. Their response will then serve as extra support for the findings.
3.5 Research Role and Ethical Considerations

It is important here to note that my role in these interviews played a key part in being able to get a good narrative. Here, I was required to transform myself from my usual role as therapist/helper into the role of “interviewer”. This new role gave me the freedom to listen to the stories with a fresh curiosity in an open atmosphere without the usual constraints. There were no expectations or requirements in this new situation and in turn, the interviewees responded to me in a new way. Friendly, accepting, and interested, I was simply there to listen intently to their stories in order to learn from them. The interviewees were encouraged to express themselves freely.

Those who suffer from alcohol misuse with episodes of relapse may be helped through my researching this phenomenon. From these interviews, I hope to find some explanations and answers in order to improve therapy through their stories of relapse. In addition, each subject was given the chance to tell his relapse story from beginning to end, and in letting it unfold, also the possibility of discovering something important on the way. Two of the subjects have expressed interest in further contact with me, as a result of these interviews — but this time, in my capacity as psychotherapist.

The interviewee was encouraged to tell his “relapse” story from beginning to end— from his way “in” to his way “out”. He was also encouraged to create metaphors in describing feelings, thoughts, actions and the concept of the relapse phenomenon itself. This amplified the communication and added yet another layer to an otherwise simple description. Again, I wish to point out my own use of the theatrical metaphor in the interview report. I hope that the reader will find their stories or performances as powerful and dramatic as I did.
Chapter IV

Results

4.1 Jim

Good Evening! And welcome to the Black Box Theater where tonight, we will be presenting the long-running stage hit performance “The Relapse Story”! Starring The Relapse Players and a host of other characters, from past and present, waiting just off-stage.

(Applause)

The houselights dim and the curtains rise. The spotlight shines down on center stage where the leading player begins his monolog:

ACT I

“Hello! My name is Jim. I’m 61 years old. I have two very successful grown children and three grandchildren of whom I’m very proud. I studied political science, economic and history at university, over the course of eight years, during my younger days. Eventually I became head of economy in a large organization. But this didn’t last— the bubble burst… I always took a bottle with me to work and had an open bottle of “light” beer on my desk plus throat lozenges to disguise the smell… I tried to fool them … yes, the bubble burst….

Let me tell you about my typical alcohol relapse. Anything can trigger me off. Mostly I get to thinking that everything is boring and routine — have lots of money but nothing is fun anymore... then, a little devil, let’s call him Faust, takes over my brain more and more- this accelerates and grows for up to 3-4 days in a row... I’m not really conscious of it but I find that get more and more irritated and restless. Then I prepare myself. First, I make sure that everything is in place- both economically and socially (that my bills are paid, that contact with my family is good). All this time, I’m talking myself into thinking that I want to change my frame of mind — anything is better than this! Yes, I know... on the outside, all’s well but I WANT A CHANGE! I want to forget the boring part. I want to fool my brain.

When Faust* has gotten its grip on me, nothing is more important. Nothing can stop me. Nothing! Nothing else matters when I’ve well decided. It’s too late. I ought to be able to control it but I can’t. Sometimes I try but the Faust devil eats up my brain....

*Faust is the protagonist of a classic German legend; a highly successful scholar, but also dissatisfied with his life, and so makes a deal with the devil, exchanging his soul for unlimited knowledge and worldly pleasures.
By the way, I have a partner—she hates alcohol! I live with her when I’m sober. I disappear for a few days (sometimes, for a week) to drink. I don’t tell her. I don’t have to! I know she knows. She knows me. She says she can’t rely on me. All alcoholics lie. I lie to her. I lie to myself too. I’ve always come back to her. You see, I rent a room in an apartment from another alcoholic. I go there when I relapse.

If someone would see me at the liquor store, hey, then I’m honest. I’ve got to do this! Nothing in the world can get me to change my mind and stop me from buying my alcohol once I’ve decided. So I go about my business... get a bottle of Explorer and pick up the beer last -‘cause it’s heavy... it’s like radar. I do it quickly. My body feels a longing... to open a beer...soon I’ll be changing...

Scene 2: (the kitchen):

I sit myself down at the kitchen table...and I turn the radio on to P1...I do the Suduko puzzle in the Metro (I like to believe that it’s good training for the brain)... yes... it’s a bit of a ritual. These patterns return over and over again. Now, I’m feeling better and better...I don’t have to think- I’ve done this so many times! I can kill some time in the ritual’s inner life. The important thing is right here and now. Time just disappears- there is no more rhythm of daytime or nighttime. I have woken up and can’t remember the entire week!

No, I can’t save alcohol for the next morning...I’ve got to drink it up...sometimes I have to go to the liquor store three times a day. I suffer and wait until the store opens at 10:00 o’clock.

Scene 3: (the living room)

My friend and I sit and drink together but he never gets sick... I can vomit up to 60-70 times! I stop caring— I don’t shower or brush my teeth (I disgust myself when I’ve sobered up). I sit there in my stinking, sweaty clothes. My body eventually says, “STOP, I CAN’T TAKE IT ANYMORE!”—I can’t eat, I vomit all night...I’ve got to get some sort of nutrition— my body screams out for food... so I go and buy some ‘nutrition drinks’ at the pharmacy— I sit there with a glass of alcohol in one hand, and the sweet nutrition drink in the other hand and try to manage...But I spew vomit like a fountain... and have terrible anxiety... I’m dehydrated and exhausted... and I think, “never again!”

I think to myself... never more...never again...I can’t drink anymore. I get caught up in negative thoughts...I think about killing myself...feel so sorry for myself...everything is ruined. What have I done wrong?? But chances are that I’ll end up there again... It’s only then that I go to de-tox - sometimes I buy some tranquilizers to de-tox myself and sometimes I sign myself into the Clinic.
ACT II

No, I don’t hide anything— I’m open with my addiction. I can’t keep that mask on for too long— it’s too obvious. My partner and I have a special relationship— we communicate in many different ways. When she asks me if I’ve been drinking, I answer her “No”. But I’m not lying! I think to myself...Hey, can’t you read me? You know I always say “no”! How can you ask me that???

I can’t drink socially...they drink so slowly. Christmas is a difficult time...I’ve got to be sober — I can’t wait for the time to go by so I can get back home...

Yeah... my family knows...they let me drink and wait it out... I avoid contact with them when I’m drinking... I try to keep my mask on. Recently I had to cancel a lunch date with my son and grandson— I explained that I was on my way into a relapse... and he says, “Well, you can call me later then, Dad”... we haven’t spoken since. Afterwards, I reluctantly contact them— I’m defensive and feel guilty— But WHY should I? It’s MY BODY! (I always try to get a reading on my son’s frame of mind through my daughter and I even check out his “facebook” page to get some sort of hint) — I’ve got a good relationship with my son and daughter. They forgive me. And they believe and hope that this is the last time- I promise them that I won’t drink anymore... and I mean it then. But they’ve accepted this. They’re sad and disappointed. My partner is angry (but she’s got a low threshold) and tired of me.

From the ages of one to twelve, I grew up in an orphanage and a foster family (a god-damn unfortunate part of my life!) because my parents were young and had drug and alcohol problems. I haven’t had strong emotional ties to them. I had to learn to stand on my own two feet early— at 15, I went off to sea (and started drinking then too).

My mother died four years ago. After that, I got caught for drunk driving. 2.36 promille. Luckily, I didn’t hurt anyone. I had a choice of two months in prison, 28 days in a treatment center or house arrest. No— I took my punishment like a man... I chose prison. That summer I took cocaine for the first time and burned a hole in my nose— the blood gushed. Nothing is left of my inheritance— 100.000:- kroner. I spent it on restaurants and cocaine— blood money. I wasn’t affected by her death. My father died two years ago— all curled up like a little chicken in bed...

I left my wife... but she wanted me to leave. I guess I’ve lived with five or six women (can’t keep track)... I can’t be alone... they all kicked me out. The fact that I’m insecure is an explanation but not a defense. I’m a calm guy— not an angry type. I can verbalize my feelings quite well— but my son closes in his feelings....

As I said, I drink because I want to change my frame of mind— but my frame of mind always gets worse. With relapse, you open a door where problems are washed away but they come back double-fold. This can’t go on... Next week, I’m entering a 28 -day treatment facility for the first time”.

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With a ray of hope, we conclude Jim’s performance. It seems that he has become caught up in a never-ending cycle of alcohol relapse. Jim lives a sober life for a while, has good contact with his live-in partner and his grown children. Gradually, he becomes restless, bored, and longs for a “change”—change that will, if only temporarily, alleviate his anxiety. After distantly from his everyday world and a bit of careful planning, Jim makes the conscious decision to drink. From then on, he experiences his behavior as automatic and without control. Jim finds himself, once again, being carried away, suspended in time, free of any responsibility, along a narrow path which ultimately leads to destruction. With this pattern there is no new input—no new ideas, no creativity, and little hope for change.

4.2 Group Results

Let us now take a look at the other results and performances in condensed form. They will be presented in the form of tables, quotations, and charts.

<table>
<thead>
<tr>
<th>Interviewee Group</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>61</td>
<td>57</td>
<td>62</td>
<td>58</td>
<td>64</td>
</tr>
<tr>
<td>Sex</td>
<td>male</td>
<td>male</td>
<td>male</td>
<td>male</td>
<td>female</td>
</tr>
<tr>
<td>Currently living together/married</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>No. of marriages/live-in partners</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>No. of children</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Currently employed/retired</td>
<td>Disability pension</td>
<td>Unemployed/Own business</td>
<td>unemployed</td>
<td>employed</td>
<td>employed</td>
</tr>
<tr>
<td>Education</td>
<td>College(8yrs)</td>
<td>College/PhD</td>
<td>college</td>
<td>college</td>
<td>College +</td>
</tr>
<tr>
<td>Have experienced employment difficulties or termination due to alcohol misuse?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

One unanticipated finding here is a high number of partners. This may be due to a difficulty in forming a close bond with a partner or to the partner’s unwillingness to be in a relationship that includes alcohol misuse. Bill usually forms relationships with women who misuse alcohol as well. This usually leads to a very unstable dynamic in the relationship.
However, Harry’s wife always joins him in his drinking period and they seem to get on very well.

The other unanticipated find here is the subjects’ high level of education. This group has inner resources and the ability of high level functioning. Three of the subjects have experienced loss of employment as a consequence of alcohol misuse. Bill works from home which not only facilitates his alcohol misuse but also keeps it hidden from his employer. Milly is employed full-time and has not, as yet, suffered any consequences from her workplace.
**Feelings and Perceived Control Before the Drinking Period**

<table>
<thead>
<tr>
<th>Before Drinking Period Begins</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience a change in emotional state? A &quot;bubble&quot;?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Length of time in this state “bubble”?</td>
<td>3-4 days</td>
<td>3 weeks</td>
<td>5-7 days</td>
<td>2-6 weeks</td>
<td>3-4 days</td>
</tr>
<tr>
<td>Initial feelings?</td>
<td>irritated/restless</td>
<td>energetic/omnipotent</td>
<td>emotionally paralyzed/drained</td>
<td>irritated</td>
<td>victimized “give up”</td>
</tr>
<tr>
<td>When does this feeling change?</td>
<td>when “decided”</td>
<td>when “drinking” starts</td>
<td>when “decided”</td>
<td>when “decided”</td>
<td>when “decided”</td>
</tr>
<tr>
<td>Perceived control in this state/ Possibility of breaking-off relapse in this state?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aware of probable relapse?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Planning relapse?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>When experience loss of control (can’t stop a drinking period)?</td>
<td>When “decided”</td>
<td>When “drinking” starts</td>
<td>When “decided”</td>
<td>When in liquor store</td>
<td>When “decided”</td>
</tr>
<tr>
<td>Initial feelings/ thoughts include “boredom”/ “emptiness”</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Experience Bodily sensations?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes-strong</td>
<td>somewhat</td>
</tr>
<tr>
<td>Usually follows the same patterns- feelings/behavior?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Many similarities were found here. Subjects were very aware of their change in emotional state, control and relapse plans.

“…I get ‘tunnel vision’…Like I’m wearing blinders. I’m in my own little world where I can’t find anything positive—consciously or unconsciously, I don’t know…”

Bill

Differences in time length in this emotional state may be due to subjects’ home situation; i.e. a subject may delay his drinking period if he has a very disapproving live-in partner as opposed to a partner who is more lenient. Dissimilarity here is with Jim in his perception of control in breaking-off a relapse—this may be partly due to his regular habit of leaving his disapproving partner/home when he feels a drinking period coming on.

Unanticipated findings here were explicit feelings of “boredom” and “emptiness.”

“Being sober is no fun, I tell you! Like, something’s missing, you know? It feels empty. Nothing happens…It was fun with alcohol! I would drink wine at my desk and get ideas… be creative! At a party you can relax and it tastes so good! Now it’s taken away…forbidden. When I can’t drink, it’s empty. Like being in a tin box that echoes…”

Milly

Simon’s predominant feeling was “omnipotence” (Simon has recently received the psychiatric diagnosis of bipolar disorder) while Bill’s initial feelings of irritation soon turned to “guilt”. Their feelings may be due to an underlying depressive state.

Experience of bodily sensations was also a common finding. There is a sense of excitement and urgency right before the drinking begins.

“…my entire body has readied itself for this relapse—both physically and psychologically. The whole process, the 14 days, has been leading up to this moment. I’d be lying if I said otherwise. I can feel it in my stomach (I even need to go to the toilet first)—throughout my body—to be able to drink! It’s a special feeling…I hurry…I buy just two beers…Yeah, yeah, I try to fool myself into believing that it’ll only be these two…self-deception…”

Bill
All subjects were aware that they usually have the same feelings and behave in a certain way before the drinking period—there is little room for variation.

Feelings and Behaviors During the Drinking Period

<table>
<thead>
<tr>
<th>During Drinking Period</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone/Secluded/Disconnected/avoid contact with others?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>“Secret”/Lies</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Miserable conditions/treat self poorly/don’t eat/dirty/sick?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Feelings of guilt/ I’m &quot;bad&quot;/negative thoughts</td>
<td>Yes</td>
<td>No</td>
<td>somewhat</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Usually follows the same patterns-feelings/behavior?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Findings here were very significant. There is a strong connection between feelings and behavior during the drinking period.

“I lie...then I have that on my conscience...all the guilt...the shame...WHAT HAVE I DONE NOW?? Then I take a drink... And don’t think that I stop there- then I drink because I’ve started to drink! I feel the alcohol in my system...Oh God... here I go again...And the anxiety and guilt and shame set in...and then I drink even more to get rid of these feelings...to push them down....it’s a vicious circle. I always try to find an excuse to drink—I say to myself, ‘Now, life is just too hellish—nothing is good!’ It might be good but just then, I choose not to see it...”

Bill

Results show that most subjects lie to their family to hide their drinking. None of the subjects misuse alcohol in a social setting (i.e. bar or social gathering) but instead, drink alone. Findings also show that most subjects do disconnect with/avoid others during the drinking period. This disconnection, which is also a part of the relapse planning process, seems to go deeper than merely the act of drinking alone.
“First, I start drinking wine and all my cares and worries melt away—I don’t think about the consequences...I shut off all those mechanisms... this works. I’m in my own world where my children don’t exist, my wife doesn’t exist and I sit at my computer or watch t.v. while the euphoria of intoxication envelops me. I relax and fall asleep. Then I wake up and try to re-create that feeling but this time, it’s not as easy to do... then comes the second phase where I drink continuously...sleep a few hours, drink... sleep a few hours, drink. I don’t eat (I’m not even hungry), don’t shave, until I can’t even stand on my own two feet. I take my chances— my heart could stop…”

Simon

Here, Simon discloses that he finds himself in a ‘different world’ by dissociating himself from reality. This may well be the defense mechanism of splitting the self— of cutting himself off from reality.

“That time, it was really bad...I hadn’t even set foot in my bedroom...I lived on my sofa...I barricaded myself in my apartment I had 5-liter jugs of alcohol and cigarettes delivered to my door...the delivery man saw how bad off I was and tried to feed me soup.... Finally, my social worker came with the police and a locksmith and they called an ambulance.”

Bill

All subjects report that they do not take care of themselves properly during a drinking period, i.e. by not eating, neglecting personal hygiene, drinking to the point of being physically ill, etc.

“...coming home after de-tox isn’t fun... coming home to that mess... bottles and cans everywhere... misery... What have I done? But that’s the way it is. I can’t touch alcohol...I lose all sense...”

Bill

Feelings of guilt are felt by most of the subjects except Simon who reports that he does not feel this way. These feelings, however, do surface for him again at the end of the drinking period. Results for Harry are somewhat dissimilar because of a live-in partner who drinks along with him. For this reason, he finds it unnecessary to drink secretly or alone or to lie to others.

All subjects were aware that they usually have the same feelings and behave in a certain way during the drinking period- there is little room for variation.
Feelings and Behaviors at the End of the Drinking Period

<table>
<thead>
<tr>
<th>End of Drinking Period</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why Stop?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Physically unable to function?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Go to De-tox?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Planned De-tox?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Difficult to re-connect with family again?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Somewhat</td>
</tr>
<tr>
<td>Shame/Guilt Feelings?</td>
<td>Yes</td>
<td>Somewhat</td>
<td>Somewhat</td>
<td>Yes-strong</td>
<td>Yes</td>
</tr>
<tr>
<td>Usually follows same patternsfeelings/behavior?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Results here were significant. Feelings of guilt may stand in the way of re-connecting with family members. Again, Harry has no need to re-connect with family as his wife is his drinking partner and he has no children.

“My family accepts me back as well... they view it as a disease—like psoriasis. Right or wrong, they just want me to get back on track and live normally again. I’ve told them all this…”

Simon

Simon perceives that his friends and family are very accepting and has no problems in re-connecting. This may be partly true due to a strong adherence to the principles of Alcoholics Anonymous where one is always readily welcomed back to the group.

All subjects, excluding Milly, had planned their inpatient detoxification period. Consumption of large amounts of alcohol together with the length of the drinking period usually precipitate a stay in a clinical setting and most of them describe the time at the Clinic as very pleasant. Thus, a certain amount of control and planning shows itself again when the drinking period ends. Milly, who does not drink as much alcohol as the others, is not in need of a stay at the Clinic.
Detoxification at the Clinic:

“Oh, it’s nice there... like being wrapped in cotton. The abstinence is gone in 3 days and I don’t have to think about anything. I’m just there. I read... have no anxiety... then, I come home—immediately I start to feel bad... “

Harry

“...until physically, I can’t take it anymore. I can’t even go out and get more alcohol... I’m anxious, abstinent and need care. My friends from AA take me to the Clinic where I stay for 5-7 days—there, it’s safe... no demands, no requirements. Thereafter, I come out and can function normally again... At the Clinic, I feel safe—no one can storm in and disturb me there...”

Simon

One unanticipated finding here is the way the subjects find it physically impossible to continue the drinking period. One may draw the conclusion that it is the subject’s own “body” which ultimately puts a stop to the drinking. The subject is physically unable to continue drinking or to obtain alcohol.

“How do I stop? My body... my head... I can’t go on working. I can’t think... make so many mistakes... I sleep poorly... lie there with my anxiety and wonder what the hell am I doing? I don’t want to feel bad feelings... I’m like a doorman at the door... I don’t let them in... I ought to, but I don’t... anxiety, guilt and shame show themselves when I’m drinking... I vomit into a bucket, unable to keep anything down. Taking care of my job and my relationship just becomes unmanageable... I tell my partner that I’ve got to go to de-tox... I come on my own and no one can decide for me.... Everyone’s watching... I get so paranoid...”

Bill

All subjects were aware that they usually have the same feelings and behave in a certain way every time they end the drinking period—there is little room for variation.
Time Periods in Relapse Behavior

<table>
<thead>
<tr>
<th>Time Periods</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Time Period between relapses</td>
<td>6 weeks-3 months</td>
<td>3-9 months</td>
<td>4 months</td>
<td>3-4 months</td>
<td>A few weeks</td>
</tr>
<tr>
<td>Average drinking period</td>
<td>2 weeks</td>
<td>6-10 days</td>
<td>2 months</td>
<td>2 weeks-2 months (recently)</td>
<td>A few days</td>
</tr>
</tbody>
</table>

Findings here show that most of the subjects have a sober period lasting from a few weeks to 9 months. Simon has been very active within Alcoholics Anonymous during the last two years and has recently moved in with his wife. This may help to explain his long sober period. Milly, on the other hand, who has shorter periods of sobriety and shorter drinking periods than the others, also has a shorter history of alcohol misuse. Her family has only recently become aware of it. She also has a highly demanding job which requires her attention daily.

Jim, Harry, and Bill, however, have an approximate average sober period of 3 months. Here, Bill explains why his sober period varies:

“You may wonder how often I relapse. Well, it varies... when I’m feeling really good and been sober a longer period, I don’t allow myself to continue. Hey, I’m not worth feeling this good! Not only that but feeling good is a strange feeling to me... I want to punish myself! Ruin it! ‘I’ve done such stupid things in my life!’— these thoughts go through my head... And then I go at it”.

Bill

The average drinking period, with the exception of Milly and Harry, is 11 days. Harry, during his two-month drinking period, does not consume as large quantities of alcohol as the others. With these findings, coupled with the information found in the previous table, one can conclude that it is physically difficult to continue drinking heavily more than two weeks.
Drinking Behavior and Perceptions About Drinking/Alcohol Misuse

<table>
<thead>
<tr>
<th>General Questions</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can drink &quot;socially&quot;?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Perceive alcoholism as a disease?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Go to AA meetings?</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>How perceive chance of change?</td>
<td>Somewhat hopeful</td>
<td>Hopeful</td>
<td>Hopeless</td>
<td>Somewhat hopeful</td>
<td>Somewhat hopeful</td>
</tr>
<tr>
<td>Misuse of other drugs?</td>
<td>Yes (a period)</td>
<td>No</td>
<td>No</td>
<td>Yes (a period)</td>
<td>No</td>
</tr>
<tr>
<td>What age began drinking?</td>
<td>15</td>
<td>15</td>
<td>16</td>
<td>19</td>
<td>20's</td>
</tr>
</tbody>
</table>

As anticipated, all subjects reported that they were unable to drink "socially" - in other words, they easily lose control over their drinking behavior (alcohol's "trigger" effect).

"So you're wondering what happens when we get invited home to friends - no problem! I proudly say 'No thanks!' The risk comes when my wife goes out of town for a few days...now that's a risk...these old patterns of behavior automatically get activated... then I've got to work hard - go to AA meetings every day, tell my wife to have phone contact with me and so on...

Simon

Three subjects perceived their alcoholism as a disease even though only one of them has had contact with a "12-step" or AA program.

"Everyone in my family knows — I'm honest about my drinking. They tell me they feel sorry for me... that I have gotten this disease...But hell! Even if this shortens my life span by a few years — life quality is important!"

Harry
“Yeah... they **wanted** to fire me— actually they don’t have the right to do that because **alcoholism is classed as a “disease”** which ought to be treated – well...instead, I quit and got three years salary...”

*Simon*

“Would you believe that I’m the only one in our family who drinks? **Why me?** Why me? Why do I have those genes? It’s a shame. I ask myself this often. “

*Bill*

This view of alcoholism is quite accepted within the medical community and popular media. Milly did **not** express this view but finds it difficult to accept that she does indeed have a problem with alcohol.

Almost all subjects report that they remain hopeful of a change in their drinking behavior and of course, have regular contact with the Clinic. It is important to note here that all subjects take up this subject on their own, without my asking. Harry, however, reported that he is without hope. His wife is his drinking-partner who always follows his lead. Alcohol plays a very large part in their relationship and in their finding closeness with one another.

Two of the subjects reported brief periods of cocaine misuse. Though misuse of other drugs is not unusual, findings here show that current misuse is limited to alcohol.
Control Questions Pertaining to Participants’ Family of Origin, their Telling of the Relapse Story, Variations in their Story

<table>
<thead>
<tr>
<th>Control Questions</th>
<th>Jim</th>
<th>Simon</th>
<th>Harry</th>
<th>Bill</th>
<th>Milly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did either/both parents have problem w/alcohol misuse?</td>
<td>Yes-both</td>
<td>No</td>
<td>Yes-both</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Difficult/traumatic childhood?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Relapse Period always same behavior/routine/feelings?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>When do you lose control of behavior?</td>
<td>When I’ve “decided”</td>
<td>When drinking has begun</td>
<td>When I’ve “decided”</td>
<td>When in liquor store/bar</td>
<td>When I’ve “decided”</td>
</tr>
<tr>
<td>Have you ever told anyone else these details/in this way?</td>
<td>No- not in this way</td>
<td>Yes-my counselor</td>
<td>No-not in this way</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Unanticipated findings here were that only two of the subjects had parents who misused alcohol. All subjects report traumatic or difficult childhoods including physical and sexual abuse, foster homes, negligence and alcoholism.

“I always show a strong and happy face outward. I couldn’t show anything when I was a child. I took care of my parents...made sure they didn’t fight too much. No, they didn’t drink much. I went between them when they fought. And I had to help work on the farm. I had to grin and bear it...there was no room for my feelings. Mother hit me when I didn’t do as she wished. My father... he got too close sometimes...he saw me as a substitute for my mother...I remember two incidents when I was six and ten...it was his way of touching me that definitely was not okay. It’s true...I moved away at sixteen to go to high school and then university.”

Milly
Loss of control is linked with a cognitive “decision” to drink by three of the subjects. Bill perceives that he loses control over his drinking behavior after he decides to step into the liquor store; i.e. when well inside the liquor store, all control is lost. Simon finds that it is the act of drinking that activates his perception of control loss. Simon and Bill seem to have automatic thoughts.

“...the behaviour... the reflex... is deeply imprinted in me. Right now I’m working on how to recognize that feeling and typical behavior (“the bubble”) in myself to be able to avoid relapse.”

Simon

Almost all of the subjects report that they had never before been given a chance to tell their relapse story in the way they had done with me, in the interview setting. This was not only a new experience but a positive one as well.

“No, no...I have never told my story like this...I met with a psychologist once but we took my story a bit at a time.... I felt that I had to weigh my words carefully. But this felt so free... “

Bill

“No, I’ve never told anyone in this way. I feel very calm right now...”

Milly
Metaphors

As said, subjects were encouraged to use metaphors or analogies to help in the telling of, and in my understanding of, their relapse stories. I will present a few here.

“A metaphor for my way into relapse? ... Let’s see... I’m a figure that has an obvious defect or deformity— has strange clothes or a strange growth (laughs) — which others can see ... but to which I’m oblivious. I feel fine! WOW! Maybe I can feel even BETTER!!! Maybe at this point I’ve already begun to relapse. I’ve psychologically drugged myself and disappeared before alcohol comes into the picture. Others have told me this— they’re not surprised...”

“You’re wondering what I say to myself while I’m drinking— Well, let me tell you...I have a fantasy picture, from my childhood, that soothes me right before I go to sleep at night... that I’m in a safe little box somewhere high up in a house. I have water and communication but no one knows that I’m there— no one requires anything from me... this gives me a calm and peaceful feeling...it’s this feeling that I try to capture when I drink. What’s the meaning of relapse? I get to go into that little box ...where I’m extremely isolated...problems or threats don’t exist (for at least a while)...and drink.”

Simon

Simon behaves “as if” all is well when on his way into a relapse. It seems that Simon seeks a safe haven where he can be free from anxiety and responsibility, at least temporarily.

“... I write down my thoughts and ambivalent feelings...Now, listen to this...It’s a science- fiction based dialog between the drunk ‘Kirk’ who has so much fun in his space station, where the colors are vibrant, birds sing and the air smells sweet and “Sober Harry” who’s so damn logical and lives on the dull, arid, boring planet earth. Sometimes Harry takes over and tries to convince ‘Kirk’ that it might be necessary to come back to earth. NO!! No...this story has nothing to do with psychology! I’m just writing about a method of transportation... that’s all... But that’s what alcohol does for me— takes me away to that wonderful planet. I’ve tried many different anti-depressants to help me to feel better while sober but they don’t help. Hmmm...maybe it’s ‘Kirk’ who’s telling me that they don’t help because then I won’t be able to visit the ‘space station’ anymore...”

Harry

Harry too, wishes to escape his anxiety and reality for a while, to be able to feel relaxed, living in the moment. But he struggles with two personas and forces living within—the socially accepted role of “Sober Harry” versus “Drunk Kirk”. Yet, his feelings of denial and strong ambivalence show through in his story.
“...a little devil...let’s call him Faust, takes over my brain more and more...”

Jim

Jim experiences, just before drinking, that he has sold his soul to the devil—a destructive force to be sure—his sins will not be forgiven.
Chapter V

Analysis—Themes and Patterns

5.1 Meaning

Most of the subjects in this research group have developed a relatively unchanging, unwavering pattern of behavior in their relapses with alcohol. They are not only in touch with the changes in their emotional state in the days or weeks preceding the drinking period, but also aware of the possibility they have then, to divert it. Despite forewarnings, they proceed to actively plan a course of action which involves not only deceiving others, but themselves as well.

Subjects act, in their stories, as if their behavior, at times, was rather rational. They minimize the consequences of their actions. They emphasize that drinking, in its initial phases, gives them a sense of relaxation, euphoria and creativity. But the reality is that the relapse always turns destructive. Here, relapse doesn’t just mean a return to drinking but involves a full-blown drinking binge that lasts for weeks on end. During this period, friends and family are temporarily shut out and forgotten. Drinking partners aren’t friends, but rather, allies in that they help the misuser rationalize his behavior. Their actions are fuelled by guilt and self-loathing. Subjects punish and degrade themselves in miserable living conditions. It is only when they have pushed their bodies to the limit, jeopardized their health, and become physically unable to continue drinking that they break away from this state and seek help.

The period spent at de-tox, is felt as a very good one—being taken care of, safe and secure, and without any desire for alcohol. After a week or so, they emerge, feeling renewed, if a bit shameful over their recent behavior. They are then eager to make amends and re-connect with the world. Until the next (relapse) time. And they continue this behavior in the very face of the fact that it is destroying their lives. Relapse provides a short-lived respite from the real world but in the end, it is counterproductive and leads nowhere.

Psychoanalytic theories of addiction address psychic conflict and affect management where alcohol serves to relieve psychic pain. Abused substances may be used to push painful thoughts from ones consciousness and to numb painful feelings. Negative affect states or psychological “inner triggers” play a large role in triggering relapse. All subjects report strong feelings of shame, guilt and “badness”. Alcohol is used to help regulate these feelings.

Subjects have been raised in environments where there has been traumatic loss, neglect, and violations of autonomy, through physical or sexual abuse, from early on. When this happens within the context of a child’s primary caregivers, it severely impacts an individual’s
ability to develop trusting and supportive relationships. Many recreate or “act-out” their trauma through their substance misuse, dysfunctional relationships and related behaviours and consequences. It seems that these victims of childhood trauma have spent much of their lives feeling responsible for the terrible things that happened to them.

It seems that guilt feelings are an important part of the relapse story and serve as an important “inner trigger”. Normal guilt serves a highly useful adaptive function and acts as a feedback signal to the person that his actions are no longer in harmony with his central core beliefs and values. For example, the realization for the alcohol misuser, that he neglects or lies to his family. But irrational guilt or “neurotic guilt” is another matter entirely. Guilt of this nature serves no useful purpose. Moreover, it often leads to paradoxical effects, serving to maintain the actions that produced it. In the alcohol misuser, irrational guilt may trigger drinking, leading to more drinking, and so on.

As dysfunctional family backgrounds and difficult childhood experiences show up in the results, socio-cultural theories may also be applied. Family systems have most certainly played, and still do play, an important role here. Subjects, with their patterns of alcohol misuse, disrupt family functioning. Subjects alienate their partners and other family members time and time again. In this way, relapse behavior becomes a family disorder.

Most of the subjects embrace the disease model of addiction where they view their alcohol misuse as an illness. This disease concept both attempts to reduce social stigma and free them from guilt about their drinking. Furthermore, with this view, recovery can only be sustained through total abstinence. Subjects describe their difficulty with social drinking and its “trigger” effect on them. The disease theory of addiction takes up the concept of “craving” or strong mental and emotional need to drink. This compulsive desire may be caused by high levels of anxiety. The subjects clearly describe this with their perceived loss of control and their ability, through strong psychological defenses, to shut out the real world.

The subjects’ pattern of relapse is cyclical and more or less predictable. They spend a few weeks drinking and then, several months sober. While in their sober period, they play many of the same roles that one would expect from any upstanding member of society—attentive spouse/partner, loving grandparent, trusted friend, helpful colleague, supportive parent, etc. Normally, these societal roles, norms, and appropriate social behaviors are upheld without too much difficulty despite there always being a certain pressure to conform. But, as the subjects have contradictory and even negative views of themselves, cognitive inconsistencies may develop. They may feel strong pressure to live up to these positive images or performances. Also, as they also show one side of themselves publicly and one side privately, they lead a sort of double-life. These conflicts may contribute to anxiety and the “inner trigger” which eventually results in relapse. They drink in an effort to reduce conflict and dissonance between who they are and what they do. They may have difficulty integrating these contradictory qualities into a coherent sense of self.
5.2 Repeating Rituals

In an attempt to control the emergence of chronic overwhelming feelings or the “inner trigger”, psychological defenses, such as denial and splitting, are mobilized. Subjects gradually distance themselves and lose their subjectivity. They long for to be free from anxiety, to feel safe, and to be released from burdens and responsibility—if only for a while. They spend some days and even weeks existing in a “bubble” where they move between fantasy and reality. After making the cognitive decision to drink, subjects slip into ritual mode. After that, all sense of control is lost. As ritual has its own momentum, they let themselves be carried away. In the inner sanctum of ritual, time stands still and the day-to-day world is far away.

Ritual is carried out in a special context, segregated from everyday existence, and in these cases, experienced alone. In this “in-between” state of liminality, status roles and ordinary social structures, and obligations are momentarily relieved. Initially, there is a sense of excitement which involves the entire body—there is a longing for change and liberation. In this context and in this state of mind, there lies much promise.

They attempt to gain control over feelings by shutting off all contact with their inner world by drinking and using strong primitive defenses, only to act out those feelings through ritual. Relapse behavior becomes automatic and according to the subjects, rarely deviates. They are now on a narrow path, in ritual mode, where plans are put into action and from where there is no return. Ritual must run its course.

The drama that the subjects repeatedly act out in their relapse ritual behaviour serves as a vehicle of both communication and transformation. Subjects have conveyed their experiences of emptiness and disconnection. Ritual, in their inebriated state, provides an illusionary context for living out their repressed feelings—their inner world. Through the performance, the subject acts out his internal experiences and unresolved conflicts with the intention of accomplishing a change. The active repetition of the trauma is an attempt to suffer it and thereby to recover from it, according to psychoanalytic view. But in the end, the subject still hasn’t found any answers or explanations, and hasn’t been freed from the relapse cycle.

At first, the drinking is enjoyable and soothing and he finds temporary relief from his relentless feelings of guilt and anxiety. But this feeling is short-lived and things soon take a turn for the worse. The drinking becomes compulsive and with that, an extreme self-punishing behavior ensues until he cannot go on. Afterwards, when he has suffered enough, he feels a sense of relief from a psychological burden. Psychic energy has been released due to his expression of repressed feelings. He has achieved a sort of redemption—a catharsis. But of course, this feeling is short-lived. Guilt and anxiety build up continuously. Relapse behavior and feelings threaten to be repeated over and over again.
5.3 Negative Learning

Subjects maintain close contact with the Clinic. They avail themselves of the many forms of care it offers: doctor visits, counselling sessions, group programs, poly-clinical contact and when needed, in-patient detoxification. And despite all these forms of treatment, subjects continue to relapse. There are no major changes in their behavior. They simply aren’t learning. They wish to hold on to their relapse behavior. Giving it up would leave them with a terrible dilemma—what to do with their anxiety? It seems that alcohol relapse is their main strategy for managing negative affect states as they are unable to use internal, reflective modes of coping. And the more subjects develop a reliance on alcohol to self-regulate and self-soothe, the less they develop capacities to achieve this normally. As time goes on, if nothing changes, these maladaptive coping techniques will only maintain or strengthen relapse behavior.

Furthermore, shame, guilt and alcohol misuse can create a negative feedback loop, which gradually increases both guilt and misuse tendencies. People begin the process when they discover that drinking can serve as a temporary escape from deeply sensed feelings of guilt and inadequacy. However, drinking often leads to guilt and/or shame producing activities as well as shame about loss of control. This sets the stage for even more drinking, shaming behaviors, more loss of control and deeper shame in a constantly descending spiral.

Subjects are ambivalent to change. They report that their drinking gives them very much but at the same time express a hope of being able to stop. After having looked at the sequence of events and how the pattern evolves in the relapse process, it seems that, for the subject, the positive aspects far overshadow the negative, thereby creating a negative feedback loop that maintains homeostasis. The relapse/ritual sequence offers, for them, a pause in an otherwise difficult, empty day-to-day existence. It also provides an illusionary stage in which to act out inner-conflicts and to meet other sides of themselves. But most of all, it brings temporary relief from the punitive superego and burden of guilt.
Chapter VI

Reflections

6.1 Reflections on Theoretical Views

I have presented theories on ritual, communication, and in order to give the reader a more comprehensive view, an array of diverse theories with differing perspectives on addiction. I will here reflect on several of them, as well as present some supporting views and theoretical approaches.

Patients who repeatedly relapse are, of course, a challenge to the professional helper’s skill and patience. Cognitive-behavioral approaches in relapse prevention treatment, which are very popular within both public healthcare and the private sector, focus on learning coping skills, stress management techniques and identifying situations with the potential to trigger negative emotions. Though certain subgroups of alcohol misusers are very responsive to this treatment intervention, I believe that relapse prevention strategies fall flat with this type of patient—they are, after all, not learning.

Norman Denzin (2009), in The Alcoholic Society, points out the “behaviorist bias” in much of the current literature on alcoholism and the recovery process, which is often preoccupied with behavior modification techniques that are intended to transform the alcoholic into a social drinker. He explains, “It does not offer an interpretation of the phenomenon of recovery as lived from the inside...it does not contain any seriously sustained consideration of the lived experiences of the active alcoholic who lives an alcoholic self, on a daily basis”. These strong and humbling words remind us that we, as professional helpers can always learn a great deal by listening to our clients’ unique stories. They are a great source of knowledge.

Of course, no single model of relapse prevention could ever encompass all individuals at different levels of behavior change, but this behavioral view is too shallow. There is a need here to resolve deeper issues. For this group, relapse is both rewarding and enticing. They are caught up in a negative feedback loop where nothing is changing. Perhaps this subgroup is not learning because the same methods are being used over and over again. Not working solutions are not only ineffective in bringing about long term change, but may even make the situation worse.

Chris Agyris, a theorist in organizational management, relabelled cybernetics terms (1st and 2nd orders of change) to “single-loop” and “double-loop” learning. Characteristic of single-loop learning is “learning by doing”. He points out that new strategies alone, will lead to change in action only. Not surprisingly, in these cases, negative feelings are suppressed and a rigid and defensive attitude develops. Being unaware of the underlying assumptions of what is driving one’s behavior inhibits effectiveness in the long term. Double-loop learning
happens when people reflect on, and change their style of learning, and when they innovate their repertoire of responses to deal with a perplexing situation (Anderson, L., 1994).

Cognitive-behavioral models, derived from social learning theory recognize that relapse is certainly a common part of recovery and teaches appropriate interventions based on learning new behaviors. Though many alcohol misusers are no doubt helped by this model, I cannot help but wonder if most of them remain in the “single-loop” of learning.

In contrast to the behavioral orientation in learning theory, whose purpose is to produce behavioral change in a desired direction, the humanistic approach to learning, based on the work of Abraham Maslow and Carl Rogers, takes an entirely different view. Here, the purpose in learning is to become self-actualized and autonomous. The educator’s role is to facilitate development of the whole person. Rogers, whose focus was on client-centered therapy, linked education to psychotherapy. To Rogers, there are two types of learning: cognitive learning, which is unimportant to the self because it doesn’t address the needs and wants of the learner; and experiential learning which is significant because it is related to learning that has relevance to the individual’s life experiences. Experiential learning is a process of constructing meaning and transforming experiences into knowledge through conversations. He states (Corey, 2009, p.165):

> Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person’s ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return to again and again, to discover a closer approximation to truth as it is in the process of becoming in me. Neither the Bible, nor the prophets— neither Freud nor research—neither the revelations of God nor man — can take precedence over my direct experience (1961).

Learning is a way of being, and we learn through experience where we are given autonomy and respect, empathy and positive regard. In this way, we build up personal responsibility, autonomy and power.

Another approach to changing or learning is that of transformative learning. This view is based primarily on the work of Robert Boyd who developed a theory of transformative education based on analytical psychology. Transformation, according to Boyd, is a fundamental change in one’s personality involving the resolution of a personal dilemma and the expansion of consciousness resulting in greater personality integration. Jack Mezirow (2000, p.7-8), educator, further explains:

> It refers to the process by which we transform our taken-for-granted frames of reference (meaning perspectives, habits of mind, mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that
they may generate beliefs and opinions that will prove more true or justified to guide action.

This learning process is quite rational on some levels but also quite an emotional or spiritual experience as well. The cognitive and the objective—the imaginative and the subjective—they both play a role in transformative learning. It involves being vulnerable and requires taking risks while one’s attitudes and assumptions are challenged. Here again, the educator’s role is that of facilitator when the goal of learning is for learners to construct knowledge about themselves, others, and social norms—and even that of role model by demonstrating a willingness to grow and change. The learner must reflect and critically assess his own assumptions in order to transform his unquestioned frames of reference. This dialogue provides the opportunity to critically examine evidence, arguments, and alternative points of view which fosters collaborative learning.

The key element of transformational learning is simple and quite exciting. Through some event, as traumatic as losing a job or as ordinary as an unexpected question, an individual becomes aware of holding a limiting or distorted view. If the individual critically examines this view, opens himself up to alternatives, and changes the way he sees things, he has transformed some part of how he makes meaning of the world (Cranton, 2002). I become aware of this, from time to time, when a patient relates how he, for example, first came in contact with the Clinic. It is almost always preceded by a disorienting dilemma. It is then that he understands that there is something wrong. It involves experiencing a deep, structural shift in the basic premises of thought, feelings, and actions that permanently alter our understanding of ourselves and our relationships. In some cases such learning takes place as a sudden breakthrough—but perhaps more commonly, through a lengthy process in which social relations play a significant role. It is typically experienced as a release both mentally and frequently, also physically (Mezirow, 2000).

This change, or creativity, occurs within a cognitive system when old habitual modes of interpretation become dysfunctional, demanding a shifting of ground viewpoint. The crisis, or breakdown, motivates the system to self-organize—embracing and integrating data of which it had been previously unconscious. Transformative learning processes are the creative function of cognitive crisis (O’Sullivan et al., 2001). Carl Rogers calls this “significant learning”—learning that implies a restructuring of the organisation of the self and thereby also a coherent restructuring and coupling of a great number of mental schemes that lead to change in the individual personality (Illeris, 2007).

Adult learning, according to contemporary philosopher and social theorist Jurgen Habermas, is integral to communication and, therefore, contemporaneous with existence. Since we all communicate, learning is a natural occurring phenomenon that can only be prevented by some act of suppression initiated by an external force. He points out, “Not learning but not
Learning is the phenomenon that calls for explanation”. In contexts that allow communicative action, the possibility of who will actually do the most learning is always open.

Habermas is best known for his *Theory of Communicative Action* where he attempts to provide a foundation for the development of universal social norms, made possible by the rationality he believes to be inherent in our communicative action. Communicative rationality is a process of problem solving and conflict resolution through open discussion. He believes rationality is achieved through communication that is open-ended, in a dialogical search for understanding. This is possible when speakers recognize the mutual demands of reciprocity and trust. His theory is a complex combination of critical theory, sociology and philosophy.

Habermas begins his construction of the theoretical framework he develops in *Theory of Communicative Action* with a theory of action. He distinguishes three types of action: instrumental, strategic and communicative. The first two are non-social and oriented toward success while the third is oriented towards understanding. In communicative action, actors in society seek to reach common understanding and to coordinate actions by reasoned argument, consensus and cooperation rather than strategic action strictly in pursuit of their own goals. He believes that unlimited and undistorted communication is basic to both political action and knowledge. He defines the concept of communicative action as a circular process in which the actor is two things in one: an initiator, who masters situations through actions for which he is accountable; and a product of the transactions surrounding him, of groups whose cohesion is based on solidarity to which he belongs, and of processes of socialization in which he is reared. Communicative action happens when attempts by people to communicate “are coordinated not through egocentric calculations of success but through acts of reaching understanding”, explains Habermas (1984). When we act communicatively, we try to step out of our normal frames of reference to see the world as someone else sees it (Brookfield, 2005).

According to Habermas, people should engage in communicative action where they set up “ideal speech situations” or situations free of power relations, allowing open debate in which rational argumentation can take place that involves statements about, and challenges to, information relating to all three of the natural, social and internal worlds. “Validity-claims” raised in communicative action relate to what Habermas calls the three worlds to which speakers relate: the objective world of physical things; the subjective world of inner experiences; and the social world of roles and norms.

The philosophical stance taken by Habermas is that reflection is a tool used in the development of particular forms of knowledge. It is through reflexive learning, which takes place through these discourses, that we thematize practical validity claims that have become problematic and redeem or dismiss them on the basis of arguments. However, in non-reflexive learning, which has no critical element, validity claims are naively taken for granted,
accepted or rejected without discursive consideration. We transform our frames of reference through critical reflection on the assumptions upon which our interpretations, beliefs, habits, or points of view are based. Self-knowledge and understanding generated through self-reflection “leads to insight due to the fact that what was previously unconscious is made conscious in a manner rich in consequences: analytic insights intervene in life”, says Habermas (Darwin, 2002, p.123). Through this process of self-reflection, change occurs.

6.2 Reflections on Research and Treatment Methodology

The subjects related their stories in a candid, straightforward, enthusiastic and moving way. I was surprised to discover that they were very aware of many of their thoughts, behaviors and feelings they have—especially before drinking. They readily focused in on, and presented me with important themes concerning control, feelings of guilt and emptiness, and childhood trauma. They were all very predictable in their relapse cycle, had an excellent ability to verbalize their feelings, were well educated, rather socially stable, and had the ability to control their drinking behavior over a course of several weeks and even months before relapsing. They also drank in a very self-destructive way and were equipped with strong, rigid, primitive defenses. And they seemed to be exceptionally satisfied after their stay at the Clinic’s inpatient detoxification facility. Over the course of the interviews it became clear that this was a special sub-group. I was intrigued. But this subgroup was clearly not really making any real progress towards change. It seems they needed a different therapeutic approach.

Inspired by the interview situation in which a new role was introduced to me—that of non-expert—and because this group responded so favorably to it, I propose a different therapeutic approach to relapse intervention, maintaining a “not-knowing” position. The therapist in the conversational or narrative approach allows himself to enter the conversation with curiosity and with an intense interest in discovery. Cecchin (1987) reminds us that, “Curiosity leads to exploration and invention of alternative views and moves, and different moves and views breed curiosity” (De Jong & Berg, 2008, p.206). The aim here is to enter a client’s world as fully as possible. Clients become the experts who are informing and share with the therapist the significant narratives of their lives. The “not-knowing” position is empathic and is most often characterized by questions that come from, as Harlene Anderson explains, “an honest, continuous therapeutic posture of not understanding too quickly” (Corey, 2009). De Jong and Berg further explain their view of the “not-knowing” position where the therapist invites the client to do more exploring, keeps the conversation open and avoids exercising his own knowledge. They add that when the therapy arrives at an impasse it may be helpful to avail ourselves of another model which may offer a different view (DeJong & Berg, 2008).
I was equally inspired by ideas of the power of reflection in transformational learning. Donald Schön (1988, p.19), philosopher and organizational theorist discusses storytelling as a mode of reflection:

...for storytelling is the mode of description best suited to transformation in new situations of action.... Stories are products of reflection, but we do not usually hold onto them long enough to make them objects of reflection in their own right.... When we get into the habit of recording our stories, we can look at them again, attending to the meanings we have build into them and attending, as well, to our strategies of narrative description.

I intend to use the relapse story as an object of reflection and framework. As in the interview situation, and using its structure, the therapist asks the client to help him understand his relapse story and lets the client guide him along in the story, disclosing his experiences and actions. The therapist listens and uses open questions which request the client’s attitudes, feelings, thoughts and perceptions. The client, in turn, feels the therapist’s genuine interest and that his story is important.

For the alcohol misuser, the relapse experience is most often comprehended as perplexing and chaotic. By deconstructing the relapse sequence together, the client and the therapist can co-explore its different phases and in this way, develop a clearer picture. The telling can help give structure and order. If possible, they could document the telling of the relapse story in written, video or audio form and look at it together—metaphors, symbols, feelings and behaviors and their inner meanings are looked at together. In disclosing the relapse story, the client sees what he hasn’t been able to see before—his chaos, lack of coping, self-punishment and self-degrading behavior. The therapist helps him examine, in the context of alcohol relapse, what his incentive is from his drinking—both a lifeline and a mortal enemy—which only pushes him deeper into the cycle of relapse.

In this approach, the intention is for them to create new meaning and new stories together. In a circular way, both client and therapist learn from each other. The story is gradually worked through and he gains insight and self-knowledge. This leads to greater control over the relapse process with the client taking a greater responsibility. The therapist gains greater knowledge as well, through linking practice with theory.

Points to consider in this approach are:

- The therapist’s role where he takes a neutral, non-directive, empathetic stance, yet manages time, space and resources. He listens, gives feedback and suggests connections and links between the client’s experiences. As he takes a non-expert role, this frees up space for discussion and exploration. In this way, the narrative or story becomes more coherent to the client and he is ultimately able to integrate it.
Examine how the client views his experience—what meanings he gives to it and what it represents to him. Step back, reflect, and ponder over these experiences and their meaning. The therapist helps him critically reflect on his assumptions, attitudes, values and beliefs in order to see how they have been constraining him. This is particularly significant when there is a contradiction between individual’s thoughts, feelings and actions. Reflection is integral to learning and in making sense of past experiences and understanding future experiences.

Explore the gap, or incongruence, between what is felt (internal experience) and what is expressed (external experience). In Rogers’ personality theory, true congruence pertains to the compliance between ideal self and actual self. Explore the client’s beliefs about who he is, and might become, and what others/society want him to be. The goal here is to find one’s authentic self—where internal and external experiences are one in the same.

Strategic points to remember:

- Re-describe what the client says as way to assure he is being heard and understood. Clarify what he is feeling in order to bring certain points into focus.

- Take problems into account but focus equally on client’s strengths and resources. This gives the client a much needed sense of competence to counteract his feelings of helplessness.

- Utilize “reframing” which is the process of stepping outside the current perspective and giving new meaning to the same situation—i.e. alcohol relapse seen as a maladaptive attempt to achieve balance or self-regulation.

- Utilize metaphor (communication on a symbolic level) as a way to enrich and enhance insight and organize perceptions. Good metaphors not only provoke new thought but help to overcome areas of rigidity.

- Use questions that convey *meta-messages*—in other words, a “message about a message”. Here, the therapist has the opportunity to deliver messages that contain implicit messages about the subject being discussed. He can, in this way, read between the lines, interpret, and send a message back, in order to stimulate deeper reflection and generate further exploration.
• Re-explore the “disorienting dilemma” which brought the client to seek help. No doubt, at one point in time, they have all experienced a discomfiting or perplexing triggering event, but because of clients’ complex defense structure, they have a habit of falling by the wayside. Originally conceived as a singular event, subsequent exploration has lead to the “disorienting dilemma” as also being viewed as a series of smaller events that may result in the initiation of transformational learning (Cranton, 2002). These events should of course, be explored—but the therapist may during the course of therapy, help the client to experience new “disorienting dilemmas”. The learning experience may be triggered by, for example, challenging the client’s old beliefs and core assumptions.

This methodology allows the psychotherapist to combine research, which is carried out together with the client, with clinical practice. This is an exceptional quality during these times when research and the concept of scientific “evidence” within psychoanalysis are being questioned and debated. G. Karlsson views psychoanalysis as both a science and a treatment. Clients come to us, Karlsson explains, because they are suffering. This suffering not only motivates the client to seek help, but together with the unwavering emotional commitment from the psychotherapist, drives the psychoanalytic process along. He sees the psychoanalytic structure as an ingenious way of connecting with psychological suffering as we examine, together in dialog with the client, the meaning of, and source of their suffering. It would be difficult to find a more systematic, thorough and/or time-consuming way of gathering data within other sciences! It is, after all, only in the clinical situation that new psychoanalytic knowledge can be generated. Lastly, Karlsson points out in reference to the “evidence” concept, that psychoanalysis is not an observing science—it is a deeply hermeneutic science brimming with inner meaning (Karlsson, 2011).

A. Frosch expands on the idea of the task of researcher and that of psychotherapist being two sides of the same coin. Firstly, he points out the task of “pattern recognition”— “Can we recognize, i.e., construct a pattern that emerges from the variable nature of the data?” He then continues to explain (2011, p. 8):

To extend the analogy between research and treatment further, I would say that research is always an interpretive process; and just as we embrace pluralism in our clinical work, we do the same in our research efforts. There are many ways of generating data and many potential interpretations of the data… it is a given, therefore, that the notion of an ‘emergent pattern of meaning’ is embedded in a context of subjectivity. This is as true for research as it is for clinical psychoanalysis.
Chapter VII

Conclusion

This study has shed new light on the alcohol relapse process. The relapse story has shown itself to be very significant and makes a great impact on our clients. But it is often, during therapy, that it is glossed over and played down. We must remove it from the shadows and look at it, examine it, reflect over it. I believe that there is much to be gleaned from the telling of the relapse story. From my side, as a professional helper, this research has led to a renewed interest in, not only the relapse story, but in all of my patients’ stories. I have found a new approach in which I find myself listening in a different way than I had done previously. I now listen in a very curious way with the patient leading me along the way. Although this therapeutic approach is still demanding, it is somehow liberating. It has breathed new life into the therapy situation. And I think, in this way too, it has empowered the patient. More responsibility is handed over to the patient while unburdening the therapist.
References


Appendix: Interview questions (est. time: 1½-2 hours)

**Background Variables:**
age, live alone/together with someone/marital status, children, family, work?

**Relapse Questions:**
How long sober? Do you remember your relapses? How long did they usually last? How many days? Does partner relapse too?

**Relapse Story Questions:**
“I would like to join you on your journey into relapse—on your way in, while there, and on your way out— I want to understand”.

**IN/Before Drinking Period:**
Let interviewee paint a picture: How does relapse begin? (Perhaps you could think back to your last relapse....?)

**Feelings** you had before drinking? Strong feelings? What has happened (argument with someone/a slight-angry)? Bad day/good day?- good/negative/ “nothing special” has happened? Bored?

**Thoughts?** What do you say to yourself —“Just this once...” , ”only one....”, “I can’t help myself...”, “I deserve it...”, “I want to be sociable ...”, “I want to prove that I can drink socially...”, “try not to think or feel anything—blank” (dissociated)?

**Actions?** What do you do? Where do you go? Give it a little time/a few days, or act directly? Do you try and fight it–break it? What happens if you get interrupted nervous–get angry–extremely annoyed/very goal oriented–distant? How long does it take before the decision is made (in hours)?

**Bodily sensations:** how does your body feel? Anxious, excited, blank/not really there/ ”out of body”?

**Metaphor**—give a picture, a description for your state of mind?

Alcohol (buy at liquor store, bar/restaurant, have already at home, get some other way/party?) Wine, beer, strong alcohol?

Feelings/thoughts then, just before purchasing?/ Just before ordering? Secretive/openly?

Feelings/thoughts just after purchasing/ordering?
During Drinking Period: What happens then? What happens if you get interrupted?

Actions? Where do you go? Openly/ Secretive?, Is it a certain day of the week/weekend? What time of day? At home? Alone/ with friends/ partner/ seek out company/ don’t answer or turn off telephone/close curtains/ ring up people and give an excuse (lie) that you’re doing something else so that they won’t disturb you? Where are the kids/your partner?

What do you begin to drink? Beer, wine, strong alcohol (certain label/brand)? How drink (slowly/enjoy?, down it fast? How much? Certain type/amount/special sequence–glass/from bottle or can?

What do you do while you’re drinking? Have certain acts, behaviors that you always do?-watch tv/see a dvd? Listen music/what kind? Call friends? Talk? Read? Seek out the opposite sex? Fall asleep? Cook/bake, clean house, do laundry, sit at computer? Smoke?

Rather be alone or with company? Do you go out while intoxicated? Stay in? Do you attempt to drive while intoxicated?

Do you eat during this phase? What do you eat? Did you make sure that you had food at home before the relapse (was it planned)?

How do you sleep?— well/poorly/not at all/feel sick or vomit?

Feelings? Positive/ negative? In-control/ can handle life../out-of-control? Mood– (happy, sad, depressed, victimized etc.)? Cry, laugh, sing, dance, get angry/ fight (at who?)?

Thoughts? Positive/negative? What do you say to yourself? Positive/negative?

Bodily sensations (calm, sick, sleepy, agitated, nervous, anxious, depressed, energized, feel great)

Next morning….. Do you have a hangover– Headache, nausea, stomach ache? What do you do about that?

How is your personal hygiene- change your clothes, shower, brush teeth? Eat?

What do next day? Ring to work/call in sick? Who do you have/avoid contact with?

Do you drink up everything you have/ leave it alone? Buy more? How do you get more? What do you buy now?

Thoughts? Confused, puzzled, victimized, defensive, find excuses, angry at….myself, someone else? What do you say to yourself?

Feelings? Mood? Sad, mad, tired, defeated, depressed, thirsty, ashamed, guilt-ridden, out-of–control/ in-control, victimized?

Actions?
Bodily sensations? Tired, sick, weak, contented?

What goes on, on day 2?? Does the relapse spin out-of-control (i.e. Don’t remember much)?

(More of same questions)

What do you say to yourself- “I’ve got to stop because...,” “I’ll taper off and drink less and less...”, “I’ll take some sedatives to help me stabilize....”?

Actions? Thoughts? What, who, (what thoughts) gets you to stop? Do you visit re-hab clinic/doctor (how is that?)? Feelings? Bodily sensations?

OUT/After Drinking Period: What happens then? Do you try to make amends—excuses, lie about relapse (amount?), lie to yourself and others (denial)?, pick an argument, clean house, have feelings of self-hate?

When do you achieve your “balance” again? When are things like normal?

Social Environment

Who do you have contact with/avoid? What do you do? Who do you have contact with?
How does your partner/family/boss react to your relapsing? Why do they react in that manner? Do they always react that way?

Control Questions:

How is your usual state? Do your relapses have more or less the same pattern/ changed over the years?

How were your parents? Did they abuse alcohol/drugs/have psychological problems?

What is the message/meaning with relapse? Can you explain the relapse?

Have you ever told anyone else these details/ in this way?